HEALTH HISTORY

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| 1. Are you having pain or experiencing discomfort at this time? 2. Do you feel nervous about having dental treatment or have you had a bad experience in a dental office? 3. Have you been a patient in the hospital during the past two years? 4. Have been under the care of a medical doctor during the past two years? Physician's Name: Shapes of the past two years? Phone: 1. Have you taken any medicine or drugs during the past two years? Are you now taking any prescription or over the counter medication? If yes, please list: 2. Are you allergic or have you reacted adversely to any of the following? Latex Other Antibiotics Nitrous Oxide Local Anesthetics Sulfa Aspirin Valium (Novocaine/Xylocaine) Tetracycline Pain Medicine If you answered yes to any of the above, please list: 1. Are you aware of being allergic to any other medications or substance? 1. If yes, please list: 2. Circle any of the following which you have had or have at present: Artificial Joints (Hip, Knee) Emphysema Cancer Hepatitis A Artificial Heart Valve Cough Chemotherapy Hepatitis B Heart Murmur Sinus Trouble Radiation Treatment Hepatitis C Heart Murmur Sinus Trouble Radiation Treatment Hepatitis C Heart Murmur Sinus Trouble Radiation Treatment Hepatitis C Rheumatise Fever High Blood Pressure Anemia Yellow Jaundice Heart Failure Disease/Attack Auto Impact Not and a paid to the problem of the didner of the plantice of the | | | | | |
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| 1. Are you having pain or experiencing discomfort at this time? 2. Do you feel nervous about having dental treatment or have you had a bad experience in a dental office? 3. Have you been a patient in the hospital during the past two years? 4. Have been under the care of a medical doctor during the past two years? Physician's Name: Phone: Phone: | | any prescription or over the | e counter medication? | YES | N |
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