

PATIENT MEDICAL HISTORY CONTINUED

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> CHEST PAINS	<input type="checkbox"/> HEART ATTACK
<input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> EASILY WINDED	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> HEART MURMUR
<input type="checkbox"/> STROKE	<input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> ANGINA	<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> FAINTING/SEIZURES	<input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CANCER
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> RADIATION THERAPY	<input type="checkbox"/> EMPHYSEMA
<input type="checkbox"/> HAY FEVER/ALLERGIES	<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> EPILEPSY/ CONVULSIONS	<input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> JOINT REPLACEMENT OR IMPLANTS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> HEPATITIS/ JAUNDICE
<input type="checkbox"/> RESPIRATORY PROBLEMS	<input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> THYROID PROBLEM
<input type="checkbox"/> STOMACH TROUBLES/ULCERS	<input type="checkbox"/> OTHER (PLEASE LIST) _____		
<input type="checkbox"/> DIABETIC	<input type="checkbox"/> EYE SURGERY		

DO YOU SMOKE? YES NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MUCH? _____

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	YES	NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS OR FOODS?	YES	NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR FOODS OR LIQUIDS?	YES	NO
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	YES	NO
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	YES	NO
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	YES	NO
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A. CLICKING OR PAIN (JOINT, EAR, SIDE OF FACE)	YES	NO
B. DIFFICULTY IN OPENING OR CLOSING OR CHEWING?	YES	NO
C. CLENCH OR GRIND YOUR TEETH?	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	YES	NO
9. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	YES	NO
10. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	YES	NO
11. HAVE YOU EVER HAD BRACES?	YES	NO
12. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	YES	NO
13. HAVE YOU BEEN INSTRUCTED ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	YES	NO

I _____ CONSENT TO THE DOING OF SUCH DENTAL PROCEDURE OR SURGERY AS IS DEEMED NECESSARY, IN THE GIVING OF SUCH ANESTHESIA, AS IS NECESSARY AND PROPER FOR SUCH PROCEDURE UPON (MYSELF, SON, DAUGHTER, WARD). I **WILL** ACCEPT FULL RESPONSIBILITY FOR ANY UNPAID BILLS. IF MY ACCOUNT IS SENT FOR COLLECTIONS TO AN ATTORNEY I UNDERSTAND I WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY'S FEES AS PERMITTED BY LAW, PLUS ALLOWABLE COURT COSTS.

X

DATE: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN (IF MINOR)