Medical History

1. List any medicines or foods you cannot take or have had a reaction to:

_____

_____

2. Are you under a doctor's care now? _____

If so, what for? _____

_____

3. What medicines are you taking now? _____

_____

What for?

4. Have you had heart trouble?	Yes	No
5. High blood pressure?	Yes	No
6. Have you gained or lost much weight recently?	Yes	No
7. Do you bleed severely after extractions?	Yes	No
8. Do you get short of breath easily?	Yes	No
9. Do you faint easily?	Yes	No

10. Check if you have or have had any of these:

☐ Stomach Trouble	☐ Rheumatic Fever
☐ Kidney Trouble	☐ Scarlet Fever
☐ Bladder Trouble	☐ Epilepsy
☐ Asthma	☐ Cancer
☐ Tuberculosis	☐ Tumor
☐ Diabetes	☐ Stroke
☐ Pneumonia	☐ Hepatitis
☐ Convulsions	☐ Allergies
☐ Anemia	☐ Other _____

How would you best describe your present health? _____

_____

Physician's Name _____

Telephone No. Area _____ No. _____

In case of emergency, who should I call? _____

This is to certify that the undersigned consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic, and I am aware of and understand the complications that could result from these procedures.

Signed _____ Date _____

Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Drivers License No. _____ Social Security# _____

Employed by _____ Retired _____

Date of birth _____

How did you find out about us? _____

Remarks: bp _____

_____

_____

_____

_____

_____

Date		Service