1. Are you having pain or discomfort this time? ---------- **Yes** **No**
2. Have you been a patient in the hospital during the past two years? ---------- **Yes** **No**
3. Have you been under the care of a medical doctor during the past two years? ---------- **Yes** **No**
   Physician's Name: _____Phone Number: _____
4. Have you taken any medication or drugs during the past two years? ---------- **Yes** **No**
5. Are you now taking any medication, drugs or pills? ---------- **Yes** **No**
   If Yes, please list:_____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ---------- **Yes** **No**
   If Yes, please list including allergy to LATEX GLOVES._____
7. Have you been on **PHEN PHEN** (Diet Pills) before? YES NO
8. Indicate which of the following you have had or have at present , circle "Yes" or "No" to each item:

Heart Failure ----------	**Yes** **No**	Artificial Joints (hip, knee, etc.) ----------	**Yes** **No**	Hepatitis B (serum) ----------	**Yes** **No**
Heart Disease or Attack -----	**Yes** **No**	Kidney Trouble ----------	**Yes** **No**	Venereal Disease ----------	**Yes** **No**
Angina Pectoris ----------	**Yes** **No**	Ulcers ----------	**Yes** **No**	A.I.D.S. ----------	**Yes** **No**
Congenital Heart Disease --	**Yes** **No**	Diabetes ----------	**Yes** **No**	H.I.V. Positive ----------	**Yes** **No**
Heart Murmur ----------	**Yes** **No**	Thyroid Problems ----------	**Yes** **No**	Cold Sores/Fever Blisters --	**Yes** **No**
High Blood Pressure ----------	**Yes** **No**	Glaucoma ----------	**Yes** **No**	Blood Transfusion ----------	**Yes** **No**
Arteriosclerosis ----------	**Yes** **No**	Cosmetic Surgery ----------	**Yes** **No**	Hemophilia ----------	**Yes** **No**
Mitral Valve Prolapse ---------	**Yes** **No**	Emphysema ----------	**Yes** **No**	Anemia ----------	**Yes** **No**
Artificial Heart Valve ----------	**Yes** **No**	Chronic Cough ----------	**Yes** **No**	Sickle Cell Disease ----------	**Yes** **No**
Heart Pacemaker ----------	**Yes** **No**	Tuberculosis ----------	**Yes** **No**	Bruise Easily ----------	**Yes** **No**
Heart Surgery ----------	**Yes** **No**	Asthma ----------	**Yes** **No**	Liver Disease ----------	**Yes** **No**
Rheumatic Fever ----------	**Yes** **No**	Hay Fever ----------	**Yes** **No**	Yellow Jaundice ----------	**Yes** **No**
Arthritis ----------	**Yes** **No**	Allergies or Hives ----------	**Yes** **No**	Epilepsy or Seizures ---------	**Yes** **No**
Rheumatism ----------	**Yes** **No**	Sinus Trouble ----------	**Yes** **No**	Fainting or Dizzy Spells ----	**Yes** **No**
Cortisone Medicine ----------	**Yes** **No**	Radiation Therapy ----------	**Yes** **No**	Nervousness ----------	**Yes** **No**
Drug Addiction ----------	**Yes** **No**	Chemotherapy ----------	**Yes** **No**	Psychiatric ----------	**Yes** **No**
Stroke ----------	**Yes** **No**	Hepatitis A (infectious) ----------	**Yes** **No**	Developmentally Disabled --	**Yes** **No**

9. Have you been diagnosed with Osteoporosis? **YES, NO**.
   If Yes, Are you taking: Didrone, Skelid, Fosamax, Boniva, Aredia or Zometa? If Yes, Please sign here:_____
10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you Are very tired? ---------- **Yes** **No**
11. Do your ankles swell during the day? ---------- **Yes** **No**
12. Have you lost or gained more than 10 pounds in the past year? ---------- **Yes** **No**
13. Do you ever wake up from sleep and feel short of breath? ---------- **Yes** **No**
14. Are you on a special diet? ---------- **Yes** **No**
15. Has your medical doctor ever said you have a cancer or tumor? ---------- **Yes** **No**
16. Do you have or have you had any disease, condition, or problem not listed?---------- **Yes** **No**
    If yes please list: _____

For Women

Are you pregnant? **NO**, **YES**, what month?_____. Are you nursing? **YES, NO**. Are you taking birth control pills? **YES, NO**.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____**Date**_____

Consent:

- I undersigned hereby authorization doctor to take x-ray, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- I understand that all responsibility for payment for dental service provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangement have been made. In the event payments are not received by the agreed upon dates, I understand that 1-1/2% finance charge (18%APR) may be added to my account.

Patient _____**Date**_____**Dr.'s Signature:**_____

Parent or responsible party _____**Relationship to patient**_____

I have recieved the Notice of PrivacyPractices:_____

I have received the Dental Materials Fact Sheet:_____

"Updating Medical History"

Date	Comments	Patient Signature	Doctor Signature