

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

CONFIDENTIAL MEDICAL HISTORY

- 1. Have you been under the care of a medical doctor during the past two years? ...YES [ ] NO [ ]
2. Who is your medical doctor of record? Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
3. Have you been a patient in the hospital or any other institution during the past two years? ...YES [ ] NO [ ]
4. Have you taken any medicine or drugs during the past two years? ...YES [ ] NO [ ]
5. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ...YES [ ] NO [ ]
6. Have you ever had any excessive bleeding requiring special treatment? ...YES [ ] NO [ ]
7. Circle any of the following which you have had or have at present:
Heart Failure, Anemia, X-ray or Cobalt Treatment, Blood Transfusion, Heart Disease or Attack, Stroke, Chemotherapy, Drug or Alcohol, Angina Pectoris, Kidney Trouble, (Cancer, Leukemia), Addiction, Abnormal Blood Press. (hi/lo), Ulcers, Arthritis, Hemophilia, Heart Murmur, Emphysema, Rheumatism, Venereal Disease, Mitral Valve Prolapse, Cough, Cortisone Medicine, (Syphilis, Gonorrhea), Rheumatic Fever, Tuberculosis (TB), Glaucoma, Cold Sores, Congenital Heart Lesions, Asthma, Pain in Jaw Joints, Genital Herpes, Scarlet Fever, Hay Fever, HIV Infection, Epilepsy or Seizures, Artificial Heart Valve, Sinus Trouble, Hepatitis A (infectious), Fainting or Dizzy Spells, Heart Pacemaker, Allergies or Hives, Hepatitis B (serum), Nervousness, Heart Surgery, Diabetes, Liver Disease, Psychiatric Treatment, Artificial Joint, Thyroid Disease, Yellow Jaundice, Sickle Cell Disease, Bruise Easily
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ...YES [ ] NO [ ]
9. Do your ankles swell during the day? ...YES [ ] NO [ ]
10. Do you use more than 2 pillows to sleep ...YES [ ] NO [ ]
11. Have you lost or gained more than 10 pounds in the past year? ...YES [ ] NO [ ]
12. Do you ever wake up from sleep short of breath? ...YES [ ] NO [ ]
13. Are you on a special diet or have you ever taken dietary suppliments such as Redux or Fen-Phen? ...YES [ ] NO [ ]
14. Has your medical doctor ever said you have a cancer or tumor? ...YES [ ] NO [ ]
15. Do you have any disease, condition, or problem not listed? ...YES [ ] NO [ ]
16. Have you or anyone in your family had a serious problem during surgery or general anesthesia? ...YES [ ] NO [ ]
17. WOMEN: Are you pregnant now? ...YES [ ] NO [ ]
Are you practicing birth control? ...YES [ ] NO [ ]
Do you anticipate becoming pregnant? ...YES [ ] NO [ ]
Are you presently nursing an infant? ...YES [ ] NO [ ]
18. Is there any other information about your health which might be important for us to know? ...YES [ ] NO [ ]

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Dr. Davidson or a hygienist at the next appointment without fail. I authorize Dr. Davidson and his licensed hygienists to administer local anesthesia for dental procedures. I am aware that certain risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions which could result in heart attack, stroke, brain damage and/or death.

Date

Signature of Patient, Parent or Guardian (OVER)