HAS PATIENT EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS? (please check which ones)

YES___NO___ HEART DISEASE

YES___NO___ HEART ATTACK

YES___NO___ PAIN OR PRESSURE IN THE CHEST

YES___NO___ SHORTNESS OF BREATH

YES___NO___ SWELLING OF THE ANKLES OR FEET

YES___NO___ RHEUMATIC FEVER OR SCARLET FEVER

YES___NO___ HIGH BLOOD PRESSURE

YES___NO___ LOW BLOOD PRESSURE

YES___NO___ DO YOU TIRE EASILY

YES___NO___ DO YOU BRUISE EASILY

YES___NO___ ASTHMA OR HAY FEVER

YES___NO___ HIVES OR SKIN RASH

YES___NO___ ARTHRITIS

YES___NO___ DIABETES

YES___NO___ FREQUENT HEADACHES

YES___NO___ LUNG PROBLEMS OR TB

YES___NO___ HEPATITIS, LIVER DISEASE OR JAUNDICE

YES___NO___ STOMACH ULCERS

YES___NO___ BLEEDING PROBLEMS

YES___NO___ ANEMIA

YES___NO___ KIDNEY DISEASE

YES___NO___ VENEREAL DISEASE, SYPHILIS OR GONORRHEA

YES___NO___ SINUS TROUBLE

YES___NO___ OTHER CHRONIC DISEASES

CHILDHOOD DISEASES_____

_____

Has patient ever had any reaction to dental anesthesia (gas or injections)? YES___ NO___

If yes, what?_____

Has patient ever had difficulty or prolonged bleeding following dental extractions? YES___ NO___

Has the patient ever received sedatives for dental procedures? YES___ NO___

If so, in what form was it given: GAS___ ORALLY___ INJECTION___

Were you pleased with the results of the sedation? YES___ NO___

FEMALES: IS PATIENT PREGNANT? YES___ NO___

Does patient have any problems associated with her menstrual period? YES___ NO___

ADDITIONAL INFORMATION_____

_____

WHO REFERRED YOU TO OUR PROGRAM_____

COMMENTS_____

_____

_____

SIGNATURE OF PERSON FILLING OUT THIS FORM_____

DENTISTS SIGNATURE_____

DATE_____

IT IS IMPORTANT THAT YOU INFORM US OF ANY CHANGE IN PATIENT'S HEALTH OR MEDICATIONS