Patients Name: ______________________________ Chart #: ______________________

Wishes to be called: ____

Physician: ____
Name Address Phone Number

Are you currently under the care of a physician? If so, for what? ______________________

____

Answer "YES" if you have or had any of the following and "NO" if you haven't.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Attack	❑ Yes	❑ No	Asthma	❑ Yes	❑ No	Hepatitis B (Serum)	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Hepatitis C	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Allergies or Hives	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Latex Allergy	❑ Yes	❑ No	Yellow Jaundice	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Hay Fever	❑ Yes	❑ No	Blood Transfusion	❑ Yes	❑ No
MVP	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No	Drug Addiction	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Kidney Trouble	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No
Heart Lesions	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No	Cancer	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No	AIDS	❑ Yes	❑ No
Heart Pacemaker	❑ Yes	❑ No	Chemotherapy	❑ Yes	❑ No	Cold Sores	❑ Yes	❑ No
Heart Surgery	❑ Yes	❑ No	Rheumatism	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Fainting Spells	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Anemia	❑ Yes	❑ No	Nervousness	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	Prolonged bleeding	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Persistent Cough	❑ Yes	❑ No	Hepatitis A (Infectious)	❑ Yes	❑ No			

Have You Ever Required Premedication Before Dental Treatment? ❑ Yes ❑ No If Yes, Why? ______________

____

Please List all Current Medications, Including Prescription and Non-prescription: ______________________

____

____

List All Drug Allergies: ____

Do You Have Any Other Medical Conditions or Problems Not Listed Above? ❑ Yes ❑ No

Please Describe: ____

For Women: Are you Pregnant? ❑ Yes ❑ No How Many Months? _____ Taking Birth Control? ❑ Yes ❑ No

Do You Want To Talk To Dr. Allen in Private About Your Health? ❑ Yes ❑ No

Signature: ______________________________ Date _____/_____/_____