Patient Name ______________________________ Date ____________

Date of Birth______________ Referring Doctor__________________

MEDICAL HISTORY

Do you want nitrous oxide (laughing gas) with your treatment? Yes_______ No_______

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ______________________________

Are you taking any prescriptions/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: ______________________________

Are you currently taking a prescription blood thinner? ❑ Yes ❑ No

For women Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week#__________

Have you ever had any of the following diseases or medical problems? *Please circle*

Heart Failure	Hyperthyroid	Prosthetic Hip or Joints
Heart Disease or Attack	Emphysema	Hepatitis
Angina Pectoris	Tuberculosis	Liver Disease
High Blood Pressure	Asthma	A.I.D.S. - H.I.V.
Heart Murmur	Anemia	Blood Transfusion
Rheumatic Fever	Sinus Trouble	Drug Addiction
Congenital Heart Lesions	Allergies or Hives	Free Bleeding
Stroke	Diabetes	Venereal Disease
Artificial Heart Valve	Ulcers	Epilepsy or Seizures
Heart Pacemaker	Radiation	Fainting or Dizzy Spells
Heart Surgery	Chemotherapy	Fever Blisters / Herpes
Mitral Valve Prolapse	Pain in Jaw Joints	Psychiatric Treatment
Steroid Treatment	Bruise Easily	Sickle Cell Disease
Hypothyroid	Glaucoma	Illicit Drug Use
Cardiac Defibrillator	Retinal Surgery	Kidney Disease

Please list other medical conditions/surgeries that you have had in the past.

____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Please check Yes or No

❑ Yes	❑ No	PENICILLIN	❑ Yes	❑ No	DENTAL ANESTHETICS
❑ Yes	❑ No	ASPIRIN	❑ Yes	❑ No	CODEINE
❑ Yes	❑ No	ERYTHROMYCIN	❑ Yes	❑ No	LATEX
❑ Yes	❑ No	TETRACYCLINE	❑ Yes	❑ No	OTHER______________

OFFICE USE ONLY

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

(OVER)