

Do you have/or have you experienced any of the following:

Allergies/Hay Fever Y N	Other Liver Disease Y N	Multiple Sclerosis Y N
Psychiatric Disorder Y N	Asthma YN	Parkinson's Disease Y N
Glaucoma YN	Cold Sores Y N	Artificial Joints Y N
Lupus YN	AIDS/HIV YN	Anemia YN
Emphysema Y N	Arthritis Y N Epilepsy Y N	Blood Transfusion Y N
Tuberculosis (TB) Y N	Chronic Fatigue Syndrome YN	High Blood Pressure Y N
Hemophilia Y N	Other Lung Disease Y N	Sexually Transmitted Infections Y N
Scarlet Fever Y N	Hepatitis A/B/C Y N	Ulcerative Colitis Y N
Diabetes YN	Rheumatic Fever Y N	Crohn's Disease Y N
Eating Disorder Y N	Ulcers Y N	Drug Addiction Y N
Heart Diseases (Angina) Y N	Stroke YN	Heart Murmur Y N
Congestive Heart Failure Y N	Mitral Valve Prolapse Y N	Artificial Heart Valve /Stent Y N
Angioplasty Pacemaker Y N	Cardiopulmonary Shunt Y N	Kidney Disease Y N

Heart Attack Y N (if yes) When: _____ Where: _____

Cancer Y N (If Yes) When: _____ Location: _____

Did you complete Radiation or Chemo Therapy? Y N (if yes then when): _____

Do you have any disease, condition or problem not listed? Y N
Do you wish to speak privately to the doctor about any medical condition? Y N
Have you had a medical examination in the last year? Y N
Have you been a patient in the hospital in the last 2 years? Y N
When walking, do you ever stop because of pain in your chest? Y N
Do your ankles swell during the day? Y N
Do you have a tendency to faint? Y N Do you have frequent, severe headaches? Y N
Do you use tobacco/marijuana or do you vape? Y N
Are you pregnant or possibly pregnant? Y N Are you breastfeeding? Y N

I, the undersigned, hereby certify that:

- All the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that it will be kept strictly confidential.
- I consent to the performing of the dental procedures to be necessary or advisable including the use of local anaesthetics.

Patient Name (Print)

Patient/Guardian Signature

Date (M/D/Y)