Patient's Last Name	First Name	Date of Birth

Please circle the correct response (Yes, No or Don't know); answer all questions.
The following questions are for our records only and will be considered confidential information.

MEDICAL HISTORY

Do you have or have you had in the past any of the following:

Question			
1. Rheumatic fever?	Yes	No	Don't know
2. Hypertension (high blood pressure)?	Yes	No	Don't know
3. Heart attack, irregular heart rate, damaged heart valves or angina?	Yes	No	Don't know
4. Stroke or TIA?	Yes	No	Don't know
5. Heart murmur or mitral valve prolapse?	Yes	No	Don't know
6. Chest pain or shortness of breath on exertion?	Yes	No	Don't know
7. Swollen ankles?	Yes	No	Don't know
8. Blood disorders such as anemia or hemophilia?	Yes	No	Don't know
9. Frequent nosebleeds, increased bruising or bleeding?	Yes	No	Don't know
10. Pacemaker/ Implanted defibrillator?	Yes	No	Don't know
11. Heart Disease/ Surgery?	Yes	No	Don't know
12. Prosthetic (Artificial) Heart Valve?	Yes	No	Don't know
13. Asthma, tuberculosis or hay fever?	Yes	No	Don't know
14. Emphysema/ Bronchitis?	Yes	No	Don't know
15. Bone Marrow or Organ transplant?	Yes	No	Don't know
16. Lupus or Autoimmune disease?	Yes	No	Don't know
17. Hives or a skin rash?	Yes	No	Don't know
18. Have you ever had a reaction to any drugs (including local anesthetics)?	Yes	No	Don't know
If yes, which drugs?			
19. Do you have any allergies (medications and/or latex)?	Yes	No	Don't know
20. Are you immunosuppressed (subject to frequent infections)?	Yes	No	Don't know
21. Have you been told you have AIDS, or an HIV positive test?	Yes	No	Don't know
22. Ulcers, stomach or intestinal problems?	Yes	No	Don't know
23. Hepatitis (jaundice) or liver disease?	Yes	No	Don't know
24. Kidney disease or Renal Dialysis?	Yes	No	Don't know
25. Diabetes (high blood sugar)?	Yes	No	Don't know
26. Frequent urination (six times/day or more)	Yes	No	Don't know
27. Increase in thirst?	Yes	No	Don't know
28. Thyroid Disease?	Yes	No	Don't know
29. Tendency to faint, have convulsions, seizure or epilepsy?	Yes	No	Don't know
30. Do you now or have you ever used tobacco products?	Yes	No	Don't know
If yes, are you interested in quitting?	Yes	No	Don't know

EXAMINER'S COMMENTS

OVER PLEASE

MEDICAL HISTORY

31. How many alcohol drinks do you consume a day?. . . . . _____ Week? ________ Month? ________
32. Do you use any recreational drugs? . . . . Yes No Don't know
    If yes, What type? ___________________ How often?________________
33. Have you ever taken an appetite suppressant (such as Fen-Phen). . . . . Yes No Don't know
34. Are you taking ANY medications now?. . . . . Yes No Don't know
    If Yes, please list the prescription drugs and non-prescription drugs
    ____
    ____
35. Have you had any eye, ear, nose or sinus problems? . . . . Yes No Don't know
36. Snoring or sleep apnea (breathing cessation while sleeping)? . . . . Yes No Don't know
37. Arthritis (painful, swollen joints)? .. . . Yes No Don't know
38. Have you ever had an artificial joint placed? .. . . Yes No Don't know
39. Cancer, chemotherapy or radiation therapy? . . . . Yes No Don't know
40. Venereal disease (syphillis, gonorrhea, herpes or other)? . . . . Yes No Don't know
41. A blood transfusion? .. . . Yes No Don't know
42. Been hospitalized, had major surgery or been seriously hurt? .. . . Yes No Don't know
43. Are you pregnant? .. . . Yes No Don't know
44. Are you taking oral contraceptives? ………………………………………. Yes No Don't know
    (Antibiotics can render oral contraceptives ineffective)
45. Are you or have you in the past received psychiatric treatment? . . . . Yes No Don't know
46. Are you being treated by a physician now? . . . . Yes No Don't know
    If Yes, for what condition?____
47. Please write your physician's name, address and phone:
    ____
    ____
48. Please list all major surgeries or hospitalizations.
    ____
    ____
49. Are you in good health? .. . . Yes No Don't know
50. Do you have any further information, not already mentioned you think may
    be helpful to us in providing your care?.. . . . . Yes No Don't know
    If Yes, please specify: ____

EXAMINER'S COMMENTS

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AUTHORIZATION: (Please read the following information carefully) I grant authority to the dentists to perform procedures & treatments. I/We agree to pay a finance charge of 1.5% per month (annual rate of 18%) on unpaid balance after 90 days & up to 100% of collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit; authorize release of any info relating to dental treatment & claims; agree to be responsible for payment of services not covered by insurance. I hereby authorize payment of all dental insurance benefits directly to: Excellence in Dentistry-Drs. Kent & Curtis Godfrey.

I certify that to the best of my knowledge, the above information is complete and accurate. If there is a change in my medical/dental history, I will make my provider aware as soon as possible.

Patient's signature____ Date ________________

Examiner's signature____ Date ________________

Review & Update

Patient's signature____ Date________________

Examiner's signature____ Date ________________