MEDICAL HISTORY

1. Are you having pain or discomfort at this time? …… Yes No
2. Do you feel very nervous about having dental treatment? …….. Yes No
3. If we could offer you a simple, inexpensive way to whiten your teeth, would you be interested? ……. Yes No
4. Are you concerned about **BAD BREATH**? …… Yes No
5. If you could wave a magic wand and change one thing about your smile, what would it be? _____
6. Have you been under the care of a medical doctor in the past two years? …….. Yes No
7. Are you now taking any medication, drugs or pills? …….. Yes No
   If yes, please list those drugs (including over-the-counter): _____
   _____
8. Have you ever had any adverse reactions to any of the following:

Nickel			
Aspirin	Nitrous Oxide	Penicillin	Demerol
Darvon	Valium	Erythromycin	General Anesthesia
Codeine	Percodan	Tetracycline	Vicodin/Hydrocodone
Local anesthetic (Novocain or Xylocaine)		Other Antibiotics	Latex

9. List any other medication or substance to which you are allergic: _____

10. Circle any of the following you have had or have at the present:

Heart Failure	Scarlet Fever	Bruise Easily	Artificial Joint (Knee/hip)
Heart Surgery	HIV/AIDS	Hemophilia	Arthritis
Angina Pectoris	Organ Transplant	Persistent Cough	Cancer/Tumor
Heart Attack/Disease	Anemia	Tuberculosis	Chemotherapy
Heart Murmur	Kidney Trouble	Emphysema	Radiation Treatment
High Blood Pressure	Frequent Thirst	Hay Fever	Stroke
Low Blood Pressure	or Urination	Asthma	Dizzy or Fainting Spells
Artificial Heart Valve	Diabetes	Sinus Trouble	Epilepsy or Seizures
Mitral Valve Prolapse	Hepatitis A (infectious)	Allergies/Hives	Glaucoma
Pacemaker	Hepatitis B/C (serum)	Ulcers	Psychiatric Treatment
Rheumatic Fever	Jaundice	Thyroid Condition	Frequent Headaches
Blood Transfusions	Liver Disease	Ankles/Legs Swell	Clicking/pain in Jaw Joint
Sickle Cell Disease	Drug/Alcohol Addiction	Cold Sores	Grinding/Clenching Teeth

11. List **ANY** other disease, condition or problem not listed _____
12. Do you know or has anyone told you that you snore? …… Yes No
13. Do you ever wake up from sleep short of breath? …… Yes No
14. Are you on a special diet? …… Yes No
15. Do you smoke or chew smokeless tobacco? …… Yes No
16. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? …….. Yes No
17. **FOR WOMEN ONLY:**
    Are you pregnant? Yes No
    If yes, what month? _____
    Are you taking birth control pills? Yes No

PATIENT OR GUARDIAN'S SIGNATURE _____ **DATE** _____