DENTAL/MEDICAL HISTORYA complete and accurate health history is essential for proper dental care

Physician's Name Physician's Office Location Date of last complete physical exam Please Circle "Yes" or "No" *Are you currently in good health? *Are you currently in good health? *Are you currently in good health? *Are you stinking medications regularly? Yes No *If "yes", please list medications, dosage, and frequency Please Check anv of the following which vou have had or have at present. Congestive Heart Failure Anemia Thyroid Disease Jaundice Heart Disease or Attack Stroke Radiation Tx. Kidney Problems or Disease Arthritis Venereal Disease HIV/AIDS Hypertension Ulcers Cancer Cough Glaucoma Epilepsy/Seizures Congenital Heart Defect Scarlet Fever Psychiatric Disorder Diabetes Hepatitis A B C Artificial Joint Heart Surgery Tuberculosis Other conditions/diseases not listed: *Have you ever had an allergic reaction to local dental anesthetics or any other drugs used in the dental office? Yes No *Have you ever had an allergic reaction to local dental anesthetics or any other drugs used in the dental office? Yes No *Po you ever experience chest pain or excessive shortness of breath with activity? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use any recreational drugs? Yes No *Do you interested in Teoth Whitening? Yes No Are you interested in Tooth Whitening? Yes No Are you interested in Tooth Whitening? Yes No Are you interested in Teoth Whitening? Yes No Are you interested in Teoth Straightening with conventional braces or Invisalign? Yes No Are you interested	Name	Male Female
Physician's Office Location	Physician's Name	
Please Circle "Yes" or "No" *Are you currently in good health? *Are you currently in good health? *Are you currently under medical treatment? *Are you taking medications regularly? *Pes No *Teryos", please list medications, dosage, and frequency Please Check any of the following which you have had or have at present. Congestive Heart Failure Heart Disease or Attack Kidney Problems or Disease Arthritis Hypertension Heart Murmur Emphysema Glaucoma Epilepsy/Seizures Congenital Heart Defect Scarlet Fever Psychiatric Disorder Hepatitis A B C Artificial Joint Heart Surgery Tuberculosis Other conditions/diseases not listed: *Have you ever had an allergic reaction to local dental anesthetics or any other drugs used in the dental office? Yes No *Do you awe accessive bleeding requiring special treatment? Yes No *Do you use more than two pillows to sleep? Yes No *Do you use any recreational drugs? Yes No Do you send sleep and a pressed and any excessive shortness of breath with activity? Please check any onditions that you have noticed: Tenderness Bad Breath Sore Areas in mouth Pain in or near ears Bleeding Gums Bad Breath Sore Areas in mouth Pain in or near ears Bleeding Gums Bad Breath Sensitivity to hot, cold, sweets (Adults Only) Are you interested in using anxiety reducing medication for dental treatment? Yes No Are you interested in Tooth Whitening? Yes No Are you interested in Tooth Whitening? Yes No Ponce of Last Dental Exam Dentist Name/Location	Physician's Office Location	Phone No
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