



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**  
*following:*

*Do you have or have you had in the past any of the*

- |  |     |    |            |
|--|-----|----|------------|
| 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? .....                                      |     |    |            |

**EXAMINER'S COMMENTS**

---



---



---



---



---



---

# 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

\_\_\_\_\_  
 \_\_\_\_\_

**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 \_\_\_\_\_