

The following information is important for your maximum safety, comfort, and optimum dental care.
This information will be held in utmost confidence by this office.

DIRECTIONS: Circle YES or NO to the following questions.

- Are you having pain or discomfort at this time? YES NO
 Do you feel very nervous about having dental treatment? YES NO
 Have you ever had a bad experience in the dental office? YES NO
 Have you been a patient in the hospital during the past two years? YES NO
 Have you been under the care of a medical doctor during the past two years? YES NO
 Have you taken any medicine or drugs during the past two years? YES NO
 Are you allergic to (i.e. itching, rash, swelling of hands, feet, or eyes) or made sick by
 penicillin, aspirin, codeine, or any drugs or medication? Please list all medications you are allergic to: YES NO
 Are you allergic to anything other than medicine? YES NO
 If so, what? _____
 Have you ever had any excessive bleeding requiring special treatment? YES NO

ARE YOU NOW TAKING:

- | | |
|--|---|
| Drugs for high blood pressure ? YES NO | Drugs for sleep? YES NO |
| Cortisone, steroids ACTH? YES NO | Anticoagulants or blood thinner? YES NO |
| Tranquilizer or sedatives? YES NO | Aspirin? YES NO |
| Insulin? YES NO | Others? YES NO |

Please list prescription medication & dosages which you are currently taking: _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Aids Related Complex |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Anemia or low platelets | <input type="checkbox"/> Thyroid trouble or goiter | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Leukemia | <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cough (Over 10 days - 2 weeks) | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Liver Disease or Yellow Jaundice | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bruise Easily |

- Do you smoke or dip tobacco? YES NO
 Do your gums bleed easily when brushing? YES NO
 Do your ankles swell during the day? YES NO
 Have you had an unexplained loss or gain of more than 10 pounds in the past year? YES NO
 Do you use more than 2 pillows to sleep? YES NO
 Do you ever wake up from sleep short of breath? YES NO
 When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or
 severe shortness of breath or because you become very tired? YES NO
 Are you on a special diet? YES NO
 Has your medical doctor ever said you have a cancer or tumor? YES NO
 Do you have any disease or condition or problem not listed? YES NO
 if so, what? _____

FOR WOMEN:

- Are you pregnant now? YES NO
 If yes, due date _____
 Are you taking birth control pills? YES NO
 Do you anticipate becoming pregnant? YES NO

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or if my medicines change, I will inform Dr. Gilder at the next appointment without fail.

Signature _____ Date _____