

MEDICAL HISTORY:

CIRCLE "YES" OR "NO" TO INDICATE IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

- | | |
|--|--------------------------------|
| YES NO AIDS, HIV POSITIVE OR HIV CARRIER | YES NO PSYCHIATRIC TREATMENT |
| YES NO CORONARY ARTERY DISEASE (ANGINA) | YES NO STROKE |
| YES NO HEART MURMUR * | YES NO PARKINSONS |
| YES NO RHEUMATIC FEVER * | YES NO EPILEPSY/SEIZURE |
| YES NO MITRAL VALVE PROLAPSE * | YES NO FAINTING |
| YES NO CONGENITAL HEART LESION | YES NO VISUAL/HEARING IMPAIRED |
| YES NO HEART SURGERY | YES NO TUBERCULOSIS |
| YES NO ARTIFICIAL HEART VALVES* | YES NO ASTHMA |
| YES NO BLOOD TRANSFUSION | YES NO ANEMIA |
| YES NO EMPHYSEMA | YES NO PROLONGED BLEEDING |
| YES NO ARTHRITIS | YES NO IMMUNESUPPRESS COND |
| YES NO RHEUMATISM | YES NO CANCER (KIND: _____) |
| YES NO OSTEOPOROSIS | YES NO RADIATION TREATMENT |
| YES NO JOINT REPLACEMENT | YES NO CHEMOTHERAPY |
| YES NO KIDNEY DISEASE | YES NO SURGERY |
| YES NO TRANSPLANT/DIALYSIS | YES NO ULCER, COLITIS |
| YES NO VENEREAL DISEASE | YES NO LIVER CONDITION |
| YES NO PREGNANT (CURRENTLY) | YES NO HEPATITIS (TYPE __) |
| YES NO LATEX ALLERGY | YES NO DIABETES (TYPE __) |
| YES NO CHEMICAL DEPENDENCY | YES NO HIGH BLOOD PRESSURE |
| YES NO UNUSUAL WEIGHT LOSS | YES NO LOW BLOOD PRESSURE |
| YES NO HERPES | YES NO LIVER DISEASE |
| YES NO NERVOUS PROBLEM | YES NO SCARLET FEVER |
| YES NO SPECIAL DIET | YES NO PACEMAKER |
| YES NO SINUS TROUBLE | YES NO GLAUCOMA |
| YES NO HEADACHE | YES NO BACK PROBLEMS |
| YES NO SHORTNESS OF BREATH | YES NO THYROID PROBLEMS |
| YES NO COUGH PERSISTENT OR BLOODY | YES NO CIRCULATORY PROBLEMS. |

*DENOTES PREMEDICATION MAY BE NEEDED

PHYSICIAN'S NAME _____ PHYSICIANS PHONE# _____

LAST PHYSICAL EXAM _____

STEROID (CORTISONE) THERAPY DURING THE LAST YEAR? _____ IF YES, FOR HOW LONG? _____

MEDICATIONS/DOSAGES _____

ALLERGIES:

- | | | | |
|-----------------|------------------|----------------------|-------------|
| ___ ASPIRIN | ___ PENICILLIN | ___ SULFA | ___ CODEINE |
| ___ IODINE | ___ BARBITURATES | ___ LOCAL ANESTHETIC | |
| ___ OTHER _____ | | | |

I STATE THAT THE MEDICAL INFORMATION IS COMPLETE & ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY GRANT PERMISSION TO DR. GOSKIN TO EMPLOY PROCEDURES NECESSARY OR ADVISABLE FOR COMPLETE DENTAL CARE.

SIGNATURE _____ DATE _____