Richard A. Gagne, DDS, Inc.

		Yes	No
1.	Have you been under the care of a physician for a medical condition in the last two years?	☐	☐
	If yes, please explain _____		
2.	Have you ever had cancer?	☐	☐
	If so, how was is it treated? Chemotherapy ☐ Radiation ☐ Other ☐		
3.	Have you had a heart attack? Year_____	☐	☐
4.	Have you ever been told that you need antibiotics prior to dental treatment?	☐	☐
5.	Do you smoke? Packs Per Day	☐	☐
6.	Do you have pain in your chest or shortness of breath?	☐	☐
7.	Do your ankles swell during the day?	☐	☐
8.	Do you ever wake up from sleep short of breath?	☐	☐
9.	Do you snore at night?	☐	☐
10.	Have you taken any illegal drugs in last five years?	☐	☐
11.	Is there a possibility that you might be pregnant?	☐	☐
12.	Have you ever had the inability to get “numb” from local anesthetics?	☐	☐
13.	Have you had a bad dental experience in the past?	☐	☐
14.	Please list any prescription drugs you are taking.		

_____

_____

15. Please check YES or NO to the following health conditions

	Yes	No
AIDS	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Angina Pectoris	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bruise easily	☐	☐
Chronic bronchitis	☐	☐
Cold sores	☐	☐
Chronic coughs	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐

	Yes	No
Seizure disorders	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Hemophilia	☐	☐
Hepatitis	☐	☐
High blood pressure	☐	☐
Kidney disease	☐	☐
Pacemaker	☐	☐
HIV	☐	☐
Psychiatric treatment	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐

	Yes	No
Tuberculosis	☐	☐
Ulcers	☐	☐
Artificial heart valve	☐	☐
Artificial joints	☐	☐
Congenital heart lesions	☐	☐
Heart murmur	☐	☐
Mitral valve prolapse	☐	☐
Are you allergic to:		
	Yes	**No**
Latex	☐	☐
Penicillin	☐	☐
Codiene	☐	☐

Your Signature _____ **Date** _____

FOR OFFICE USE ONLY

Date	Doctor	ASA	Date	Doctor	ASA