curt Hinkle DDS
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Welcome!

Do you have or ever had any of the Following? Please read carefully and check those that apply.

- ❑ AIDS
- ❑ Allergies _____
  _____
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Disease
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Cold Sores/Fever Blisters
- ❑ Contact Lenses
- ❑ Cortisone Medication
- ❑ Diabetes
- ❑ Diet (Special/Restricted)
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ H.I.V Positive
- ❑ Head Injuries
- ❑ Heart (Attack, Disease, Surgery)
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex Sensitivity
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Psychiatric/Psychological Care
- ❑ Pregnancy
  Due date: _____
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Smoke/Chew Tobacco
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ Allergic/Adverse Reaction To Medication or Any Substance, Please Specify:
  _____
  _____
- ❑ Other: _____
  _____

Please list your medications: _____

_____

_____

- Have you ever had any complications following dental treatment? ❑ Yes ❑ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency dental treatment? ❑ Yes ❑ No
  If yes, please explain: _____
- Are you now under the care of a physician? ❑ Yes ❑ No
  If yes, please explain: _____

Name of Physician: _____
Phone: _____

- Do you have any health problems that need further clarification?: ❑ Yes ❑ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Doctor

Thank you for choosing Dr. Curt Hinkle