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DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

GOVERNMENT OF GUAM

MEDICAL HISTORY AND CONSENT FOR GUAM GERIATRIC DENTAL PROGRAM

DATE: _____

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
NUMBER AND STREET VILLAGE

TELEPHONE #: _____ _____
HOME WORK

DATE OF BIRTH: _____ S.S. #: _____

PHYSICIAN'S NAME: _____

PLEASE ANSWER EACH QUESTION

		CHECK ONE Yes	No
1)	Have you ever been hospitalized?	☐	☐
2)	Are you currently under the care of a physician?	☐	☐
3)	Are you taking any medications now?	☐	☐
4)	Are you allergic to penicillin, aspirin, codeine, novocaine, or any other drugs or medication?	☐	☐
5)	Have you ever had excessive bleeding associated with previous extractions, surgery, or trauma?	☐	☐

6) Check any of the following which you have had:

☐ Heart Trouble	☐ Asthma
☐ Heart Murmur	☐ Allergies
☐ Rheumatic Fever	☐ Arthritis
☐ High Blood Pressure	☐ Tuberculosis
☐ Stroke	☐ Hepatitis
☐ Anemia or Low Blood	☐ Blood Transfusions
☐ Diabetes	☐ Epilepsy (Seizures)
☐ Kidney Disease	☐ Any other health problems

Please read the following and then sign.

I have voluntarily reported to a Department of Public Health and Social Services Dental Clinic seeking immediate relief of dental pain and toothache on an emergency basis.

I have discussed my dental problem with a dentist and do consent to the treatment recommended to relieve my discomfort.

_____
SIGNATURE