MEDICAL HISTORY

PATIENT'S NAME ______________________________ Date of Birth ____________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE DON'T KNOW AFTER THE QUESTION.

1. Physicians Name ____

   Address____
2. Are you under a physicians care? ……………………………………………………………… YES NO
3. When was your last complete physical exam? ______________________________
4. Are you taking any medications-prescription or over-the-counter? …………………………… YES NO
   Please list your medications ____
5. Are you allergic to any medications or antibiotics such as penicillin or Sulfites? …………… YES NO
   If so describe:____
6. Have you reacted adversely to codeine, nitrous oxide, or local anesthetics (Novocaine or Xylocaine)? ……………………………………………………………… YES NO
7. Are you sensitive to any metals or latex? ……………………………………………………… YES NO
8. Are you Pregnant or suspect you may be? ……………………………………………………… YES NO
9. Do you use any birth control medications? …………………………………………………… YES NO
10. Have You ever been treated for or been told you might have heart disease? ……………… YES NO
11. Do you have a pacemaker or an artificial heart valve implant? ……………………………… YES NO
12. Have you ever had rheumatic fever? …………………………………………………………… YES NO
13. Are you aware of any heart murmurs? ………………………………………………………… YES NO
14. Have you ever taken Redux or Phen Fen? ……………………………………………………… YES NO
15. Do you have any artificial joints/prosthesis? ………………………………………………… YES NO
16. Have you has a serious illness or major surgery in the last five years? ……………………… YES NO
17. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? Please describe. ______________________________ YES NO
18. Do you have inflammatory diseases, such as arthritis or rheumatism? ……………………… YES NO
19. Do you have high or low blood pressure? ……………………………………………………… YES NO
20. Do you have any blood disorders, such as anemia, leukemia, etc? ………………………… YES NO
21. Have you ever bled excessively after being cut or injured? ………………………………… YES NO
22. Do you have any kidney problems? …………………………………………………………… YES NO
23. Do you have any liver problems? ……………………………………………………………… YES NO
24. Do you have diabetes? …………………………………………………………………………… YES NO
25. Do you have asthma? …………………………………………………………………………… YES NO
26. Do you have epilepsy or seizure disorders? …………………………………………………… YES NO
27. Have you tested positive for HIV? ……………………………………………………………… YES NO
28. Do you have AIDS? ……………………………………………………………………………… YES NO
29. Have you had or do you test positive for Hepatitis? ………………………………………… YES NO
30. Do you or have you had tuberculosis? ………………………………………………………… YES NO
31. Do you smoke, chew, use snuff or any other forms of tobacco? …………………………… YES NO
32. Do you habitually use controlled substances? ………………………………………………… YES NO
33. Do you have any disease, condition, or problem not listed? ………………………………… YES NO
    If so, please explain:____
34. Is there anything else we should know about your health that is not covered on this form? YES NO
    ____
35. Would you like to speak to the Doctor privately about any problem? …………………… YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

*SIGNATURE*____

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) ______________________________
And further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I give permission for release of any pertinent information about my health that may be necessary for proper diagnosis and treatment. You have my permission to use clinical diagnostic materials such as x-rays, models, photographs, etc. for display or teaching purposes.

Patient ______________________________ Date____________ Reviewed by______________________________

Signature____ Date__________________