

MEDICAL HISTORY

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Emphysema.....	Yes	No	Cold Sores.....	Yes	No
Chest Pain	Yes	No	Chronic Cough.....	Yes	No	Fever Blisters.....	Yes	No
Congenital Heart Disease..	Yes	No	Cancer.....	Yes	No	Blood Transfusion.....	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No	Hemophilia.....	Yes	No
High Blood Pressure.....	Yes	No	Asthma	Yes	No	Sickle Cell Disease.....	Yes	No
Mitral Valve Prolapse	Yes	No	Sleep Apnea	Yes	No	Liver Disease.....	Yes	No
Artificial Heart Valve	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders...	Yes	No
Heart Stent/Shunt	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures.....	Yes	No
Heart Pacemaker	Yes	No	Radiation Therapy.....	Yes	No	Fainting or Dizzy Spells..	Yes	No
Rheumatic Fever	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Tumors.....	Yes	No	Psychiatric Care.....	Yes	No
Stroke.....	Yes	No	Hepatitis A (Infectious)..	Yes	No	Sinus Trouble.....	Yes	No
Artificial Joints	Yes	No	Hepatitis B (Serum).....	Yes	No	Allergy to Jewelry	Yes	No
Kidney Trouble.....	Yes	No	Venereal Disease.....	Yes	No	Allergy to Metal	Yes	No
Diabetes.....	Yes	No	A.I.D.S.....	Yes	No	TMJ Disorder	Yes	No
Thyroid Problems.....	Yes	No	H.I.V. Positive.....	Yes	No	Smoke / Chew Tobacco..	Yes	No

Have you been prescribed a C-Pap device? Yes No
 If yes, do you currently use it? _____

Do you have or have you had any disease, condition or problem not listed? Yes No
 If yes, please list _____

Are you under the care of a physician? Yes No
 If yes, please explain _____
 Name of physician _____

Are you taking any medication, drugs or pills now? Yes No
 If yes, please list: _____

Are you aware of having an allergy (or adverse reaction) to any medication or substance? Yes No
 If yes, please list: _____

Women

Are you: **Pregnant?** Yes _____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of **(Name of Patient)** _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

Patient _____ **Date** _____ **Witness** _____

Parent or Responsible Party _____ **Relationship to Patient** _____