

MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

1. Are you currently under the care of a physician? Please circle Yes or No

Please explain: \_\_\_\_\_

2. Are you allergic to any of the following: Y / N Dental Anesthetics Y / N Aspirin Y / N Erythromycin

Y / N Tetracycline Y / N Latex Y / N Codeine Y / N Penicillin

3. Do you have any other allergies? \_\_\_\_\_

\*\*\*Please circle Y or N and specific item as it applies to you\*\*\*

Y/N Heart attack, Heart trouble, Heart surgery \_\_\_\_\_

Y/N Angina \_\_\_\_\_

Y/N High Blood Pressure \_\_\_\_\_

Y/N Prolapsed Mitral Valve/Heart Murmur \_\_\_\_\_

Y/N Artificial Heart Valve \_\_\_\_\_

Y/N Heart condition you were born with \_\_\_\_\_

Y/N Pace Maker or defibrillator \_\_\_\_\_

Y/N Rheumatic Fever or Scarlet Fever \_\_\_\_\_

Y/N Blood Disease/Transfusion \_\_\_\_\_

Y/N Excessive Bleeding or hemophilia \_\_\_\_\_

Y/N Anemia/Easy Bruising \_\_\_\_\_

Y/N Stroke \_\_\_\_\_

Y/N Allergies/Hives/Skin Rash/Latex Allergy \_\_\_\_\_

Y/N Asthma/Persistent Cough/Sinus Problems \_\_\_\_\_

Y/N Tuberculosis/Emphysema \_\_\_\_\_

Y/N Cancer Treatment/Radiation Therapy \_\_\_\_\_

Y/N Ulcers/Gastritis/Colitis/Hernia \_\_\_\_\_

Y/N Artificial Joints anywhere in your body \_\_\_\_\_

Y/N Arthritis \_\_\_\_\_

Y/N Venereal Disease \_\_\_\_\_

Y/N AIDS/HIV infection \_\_\_\_\_

Y/N Liver Disease/Hepatitis \_\_\_\_\_

Y/N Shingles/Herpes/Fever Blisters \_\_\_\_\_

Y/N Glaucoma/Eye Surgeries \_\_\_\_\_

Y/N Epilepsy/Seizures/Fainting spells \_\_\_\_\_

Y/N Psychiatric Care \_\_\_\_\_

Y/N Kidney Trouble \_\_\_\_\_

Y/N Substance Abuse \_\_\_\_\_

Y/N Diabetes \_\_\_\_\_

5. Have you taken Fen-Phen or any other weight loss drug? Yes or No Which ones? \_\_\_\_\_

6. Have you ever had any complications following dental treatment? Yes or No If yes please explain \_\_\_\_\_

7. Have you been admitted to a hospital or needed emergency care during the past two years? \_\_\_\_\_

8. Please list any past surgery: \_\_\_\_\_

9. Please list your medications: \_\_\_\_\_

10. Is there anything else we should know about your health? \_\_\_\_\_

**Women only:**

Y / N Currently pregnant      Y / N Nursing      Y / N Female problems  
Week #: \_\_\_\_\_      Are you taking birth control pills? \_\_\_\_\_

**\*\*\*SEVERAL STUDIES HAVE SHOWN THAT TAKING THE FOLLOWING MEDICATIONS MAY REDUCE THE EFFECTIVENESS OF YOUR BIRTH CONTROL PILLS: ANTIBIOTICS - SULFA DRUGS – PAIN KILLERS – TRANQUILIZERS – SEDATIVES – ANTIHISTAMINES.**

**CONSENT FOR SERVICES**

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

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis. I consent to the taking of photographs and x-rays before, during, and after treatment, as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for these photographs, x-rays and records to be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phonebooks, television), and publication in professional journals. I further understand that if the photographs, x-rays, and records are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I am responsible for payment of all services rendered on my behalf or my dependents.

Sign here to verify: \_\_\_\_\_  
Signature (parent or guardian if patient is a minor)

\_\_\_\_\_  
Date