

Medical History

1. Are you having pain or discomfort at this time?..... YES NO
 2. Have you been a patient in the hospital during the past two years? YES NO
 3. Have you been under the care of a medical doctor during the past two years? YES NO
 Physician's Name: _____ Phone No. _____
 Address: _____
4. Have you taken any medication or drugs during the past two years? YES NO
 5. Are you now taking any medication, drugs or pills? YES NO
 If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance..... YES NO
 If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item.
- | | | | | | | | | |
|-------------------------------|-----|----|-------------------------------------|-----|----|------------------------------|-----|----|
| Heart Failure..... | YES | NO | Artificial Joints (Hip, Knee, etc.) | YES | NO | Hepatitis B (serum)..... | YES | NO |
| Heart Disease or Attack..... | YES | NO | Kidney Trouble..... | YES | NO | Venereal Disease..... | YES | NO |
| Angina Pectoris..... | YES | NO | Ulcers..... | YES | NO | A.I.D.S..... | YES | NO |
| Congenital Heart Disease..... | YES | NO | Diabetes..... | YES | NO | H.I.V. Positive..... | YES | NO |
| Heart Murmur..... | YES | NO | Thyroid Problems..... | YES | NO | Cold Sores/Fever Blisters... | YES | NO |
| High Blood Pressure..... | YES | NO | Glaucoma..... | YES | NO | Blood Transfusion..... | YES | NO |
| Arteriosclerosis..... | YES | NO | Cosmetic Surgery..... | YES | NO | Hemophilia..... | YES | NO |
| Mitral Valve Prolapse..... | YES | NO | Emphysema..... | YES | NO | Anemia..... | YES | NO |
| Artificial Heart Valve..... | YES | NO | Chronic Cough..... | YES | NO | Sickle Cell Disease..... | YES | NO |
| Heart Pacemaker..... | YES | NO | Tuberculosis..... | YES | NO | Bruise Easily..... | YES | NO |
| Heart Surgery..... | YES | NO | Asthma..... | YES | NO | Liver Disease..... | YES | NO |
| Rheumatic Fever..... | YES | NO | Hay Fever..... | YES | NO | Yellow Jaundice..... | YES | NO |
| Arthritis..... | YES | NO | Allergies or Hives..... | YES | NO | Epilepsy or Seizures..... | YES | NO |
| Rheumatism..... | YES | NO | Sinus Trouble..... | YES | NO | Fainting or Dizzy Spells.... | YES | NO |
| Cortisone Medicine..... | YES | NO | Radiation Therapy..... | YES | NO | Nervousness..... | YES | NO |
| Drug Addiction..... | YES | NO | Chemotherapy..... | YES | NO | Psychiatric Treatment..... | YES | NO |
| Stroke..... | YES | NO | Hepatitis A (infectious)..... | YES | NO | Developmentally Disabled.. | YES | NO |

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you very tired?..... YES NO
9. Do your ankles swell during the day?..... YES NO
10. Do you use more than two pillows to sleep?..... YES NO
11. Have you lost or gained more than 10 pounds in the past year?..... YES NO
12. Do you ever wake up from sleep and feel short of breath?..... YES NO
13. Are you on a special diet?..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor?..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
 If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? Yes, what month? ____ No, Are you nursing? Yes No
 Are you 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 truthfully and to the best of my knowledge.

Patient Signature _____ Date: _____

CONSENT:

- The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date: _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____