Medical History

These questions are for your benefit and assume that treatment will take into consideration your past health status. Some questions may seem unrelated to your dental condition but they are associated with proper oral health care.

MEDICAL HISTORY

1. Are you now under the care of a physician? If YES please provide name and phone number________________________. **Yes No**
2. Have you ever had any serious illness or operation including cosmetic surgery?.. **Yes No**
3. Are you taking any medication? If yes what____. **Yes No**
4. Have you ever been pre-medicated with antibiotics for your dental treatment?.. **Yes No**
5. Are you taking any recreational drugs? Do you have a drug addiction?.. **Yes No**
   a. If YES please explain____
6. Are you taking any blood thinners? ☐Coumadin ☐Plavix ☐Etc.____ **Yes No**
7. Have you taken FEN-PHEN or REDUX or PONDIMIM?... **Yes No**
8. Do you wear a cardiac pace maker, or have had heart surgery (when)? ____ **Yes No**
9. Do you have any disease, condition or problem not list that you think I should know about?________________________ **Yes No**
10. Are you pregnant (Women)?.. **Yes No**
11. Do you take birth control pills (Women)?.. **Yes No**
12. Are you sensitive or allergic to : ☐Penicillin ☐Erythromycin ☐Tetracycline ☐Sulfa drugs ☐Aspirin ☐Codeine ☐Latex ☐Other If other, please list____.
13. Do you have any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Recent Weight Loss	☐	☐
Alzheimer Disease	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Drug Addiction	☐	☐	Herpes	☐	☐	Shingles	☐	☐
Arthritis/Gout	☐	☐	Easily Winded	☐	☐	High Blood Pressure	☐	☐	Sickle Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Emphysema	☐	☐	Hives or Rash	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Epilepsy oe Seizures	☐	☐	Hypoglycemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Asthma	☐	☐	Excessive Bleeding	☐	☐	Irregular Heart beat	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Fainting Spells/Dizziness	☐	☐	Leukemia	☐	☐	Thyroid Disease	☐	☐
Blood Transfusion	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Bruise Easily	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Tumors or Growth	☐	☐
Cancer	☐	☐	Hay fever	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers	☐	☐
Chemotherapy	☐	☐	Heart attack/Failure	☐	☐	Pain in Jaw joint	☐	☐	Venereal Disease	☐	☐
Chest Pains	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Yellow Jaundice	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Pace Maker	☐	☐	Radiation Treatment	☐	☐		☐	☐

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocain, etc)?... **Yes No**
2. Have ever had any unfavorable reactions from a local anesthetic?.. **Yes No**
3. Have you ever had any serious trouble associated with any previous dental treatment?.. **Yes No**
   If YES please explain.____
4. How long since your last Dental Treatment and X rays? ____
5. Does dental treatment make you nervous? **Yes No** If YES check✓: ☐Slightly ☐Moderate ☐Extremely

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health Questionnaire, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. I also acknowledge that I been Provide a copy of **Dental Material Fact Sheet** adopted on October 17,2001, as well as a copy of the **"Notice of Privacy"** taking effect on April 14, 2003, copies of which will be given to me upon my request.

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ **DATE** ______________**Reviewed By:____________**
Authorization must be signed by the patient, or the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.
Relationship to Patient:____________________

Year 1 Review Date:	**Year 2 Review Date:**	**Year 3 Review Date:**
Note Changes:	**Note Changes:**	**Note Changes:**
Patient Signature:	**Patient Signatures:**	**Patient Signature:**
Doctor's Signature:	**Doctor's Signature:**	**Doctor's Signature:**
BP_______/Pulse_______/ By________	**BP_______/Pulse_______/ By________**	**BP_______/Pulse_______/ By________**