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

Pharmacy Name: _____ **Phone Number**: _____

Pharmacy Address: _____

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.

Signature _____ **Date** _____ **Witness** _____

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

Melanie Pugh, DMD, PA
Gentle Family & Cosmetic Dentistry

___ **I DO NOT** give the office of Dr. Melanie Pugh my permission to discuss my account, treatment or any other protected health information with anyone other than myself.

___ **I DO** give the office of Dr. Melanie Pugh my permission to discuss my account, treatment, or any other protected health information with the following:

_____ _____

NAME RELATIONSHIP

_____ _____

NAME RELATIONSHIP

May we leave a message at home confirming or cancelling an appointment?

YES NO

May we leave a message at your place of employment to have you return our call?

YES NO

_____ _____

Signature **Date**