Medical History

Physician's Name/Phone #_____

Have you had any medical care within the past two years? Yes/No

If yes, please list _____

Have you taken any medications in the last 2 years? Yes/No

If yes, please list_____

Are you currently taking any medication, drugs, pills, or aspirin on a regular basis? Yes/No

If yes, please list_____

Have you ever taken prescription medications for weight loss? Yes/No

If yes, did you take the following Fen-Phen Pondimen Redux Other

If yes, did you have a medical exam for heart issues? Yes/No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other? Yes/No

Are you aware of having allergic (or adverse) reaction to any substance or medication? Yes/No

Have you been hospitalized in the last five years? Yes/No

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

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No
Chest pain	Yes	No	Diabetes	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No
Hepatitis A B C	Yes	No	Venereal Disease	Yes	No
A.I.D.S./H.I.V. Positive	Yes	No	Cold Sores/Fever Blisters	Yes	No
Blood Transfusion	Yes	No	Hemophilia	Yes	No
Sickle Cell Disease	Yes	No	Bruise Easily	Yes	No
Liver Disease/Yellow Jaundice	Yes	No	Neurological Disorders	Yes	No
Epilepsy or Seizures	Yes	No	Fainting or Dizzy Spells	Yes	No
Nervous/Anxious	Yes	No	Psychiatric /Psychological Care	Yes	No

Do you have any other disease, condition, or problem not listed? Yes/No

If yes, please list _____

Women: Are you pregnant or think you could be pregnant? Yes/No Months?_____ Nursing?_____

Are you taking any birth control medications? Yes/No

Consent for Treatment

*I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my 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 care.

*I agree to the use of anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I fully can ask for a complete recital of any possible complications.

*I give consent to the doctor's or designated staff's use of and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations.

Patient's Signature_____ Date_____

Parent/Responsible Party's Signature_____ Relationship to Patient_____