

MEDICAL HISTORY

PATIENT NAME _____ MEDICAL ALERT _____

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
 If yes, please list name and dosage _____

4. Are you allergic to: Penicillin _____ Codeine _____ Local injected anesthetics _____
 Other medications _____
5. Are you subject to prolonged bleeding? Yes No
6. 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	Glaucoma.....	Yes	No	Liver Disease.....	Yes	No
Chest Pain.....	Yes	No	COPD.....	Yes	No	Hepatitis A (infectious) B (serum)....	Yes	No
Congenital Heart Disease.....	Yes	No	Emphysema.....	Yes	No	Hepatitis C.....	Yes	No
Heart Murmur.....	Yes	No	Chronic Cough.....	Yes	No	Veneral Disease.....	Yes	No
High Blood Pressure.....	Yes	No	Tuberculosis.....	Yes	No	A.I.D.S. or A.R.C.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Asthma.....	Yes	No	H.I.V. Positive.....	Yes	No
Artificial Heart Valve.....	Yes	No	Lung Disease.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Heart Pacemaker.....	Yes	No	Hay Fever.....	Yes	No	Herpes.....	Yes	No
Rheumatic Fever.....	Yes	No	Latex Sensitivity.....	Yes	No	HPV.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Allergies or Hives.....	Yes	No	Anemia.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Neurological Disorders.....	Yes	No
Artificial Joints (hip, knee, etc.).....	Yes	No	Radiation Therapy.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Kidney Disease.....	Yes	No	Chemotherapy.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Ulcers.....	Yes	No	Tumors.....	Yes	No	Nervous/Anxious.....	Yes	No
Diabetes.....	Yes	No	Cancer.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No
Thyroid Problems.....	Yes	No						

7. Have you now, or have you in the past, taken bisphosphonates (Boniva, Fosamax, Zometa)? Yes No
8. Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list: _____
9. **WOMEN.** Are you: **Pregnant?** Yes, _____ Months No **Nursing?** Yes No
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 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.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices.

I, _____ understand that by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment, activities and health care operations.

Signature _____ Date _____