MEDICAL HISTORY

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Name:____

1. Physician's Name ____
2. Address ____
3. When was your last complete physical exam? ____
4. List all medications including prescription, over-the-counter and natural:
   ____
   ____
5. List any medications you are allergic to: ____

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6. Have you ever had a bad reaction to pain medication? ....
7. Have you ever had a bad reaction to anesthetics (Novocaine or xylocaine)? ....
8. Have you ever been treated for or been told you might have heart disease? ....
9. Do you have an artificial heart valve or congenital heart defect? ....
10. Have you ever been told to take an antibiotic prior to a dental appointment? ....
11. Do you snore or have a sleeping disorder? ....
12. Do you get severe headaches or migraines? ....
13. Do you have reflux (GERD) or persistent heartburn? ....
14. Do you have a dry mouth? ....
15. Have you ever had a stroke? ....
16. Do you have any artificial joints? ....
17. Have you ever taken a bisphosphonate for bone health or cancer? ....
18. Have you had a serious illness or major surgery in the last five years? ....
19. Have you ever had radiation or chemo treatment? ....
20. Do you have any inflammatory disease such as osteo- or rheumatoid arthritis? ....
21. Do you have high or low blood pressure? ....
22. Do you have any blood disorders, such as anemia, leukemia, etc.? ....
23. Have you ever bled excessively after being cut or injured? ....
24. Do you have any kidney problems? ....
25. Do you have any liver problems? ....
26. Do you have diabetes? ....
27. Do you have asthma? ....
28. Do you have any seizure disorders? ....
29. Have you tested positive for HIV or AIDS? ....
30. Have you ever tested positive for hepatitis? ....
31. Do you or have you had tuberculosis? ....
32. Do you smoke, chew, use snuff or any other forms of tobacco? ....
33. Do you use controlled substances? ....
34. Are you pregnant or suspect you may be? ....
35. Do you use birth control medication? ....
36. Would you like to speak to the doctor privately about any problem? ....
37. Please list any disease, condition, or problem not listed:
    ____
    ____

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above patient and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient/Guardian____

Signature ____ Date ____________

Provider Signature ____ Date _____________