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	Thyroid Problems	Yes	No	Liver Disease	Yes	No
Chest Pain	Yes	No	Glaucoma	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Congenital Heart Disease	Yes	No	Contact Lenses	Yes	No	Hepatitis C	Yes	No
Heart Murmur	Yes	No	Emphysema	Yes	No	Veneral Disease	Yes	No
High Blood Pressure	Yes	No	Chronic Cough	Yes	No	A.I.D.S. or A.R.C.	Yes	No
Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No	H.I.V. Positive	Yes	No
Artificial Heart Valve	Yes	No	Asthma	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Pacemaker	Yes	No	Lung Disease	Yes	No	Herpes	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Blood Transfusion	Yes	No
Arthritis/Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Anemia	Yes	No
Stroke	Yes	No	Allergies or Hives	Yes	No	Bruise Easily	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Sinus Trouble	Yes	No	Neurological Disorders	Yes	No
Kidney Trouble	Yes	No	Radiation Therapy	Yes	No	Epilepsy or Seizures	Yes	No
Ulcers	Yes	No	Chemotherapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Tumors	Yes	No	Nervous/Anxious	Yes	No
Diabetes	Yes	No	Cancer	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Have you lost or gained more than 10 pounds in the past year? ..... 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 _____