Medical History

4 Physician: _____
Address: _____
Date of last physical exam: _____

Have you been a patient in the hospital during the past two years? ☐Yes ☐No
For What? _____
_____

Have you been under the care of a medical doctor during the past two years? ☐Yes ☐ No
For What? _____
_____

Have you taken any medicine or drugs the past two years? ☐Yes ☐ No
What? _____
_____
_____
_____
_____
_____

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ☐Yes ☐ No
If so what? _____

Have you ever had any excessive bleeding requiring special treatment? ☐Yes ☐ No

Are you on a special diet? ☐Yes ☐No

Has your medical doctor ever said you have cancer or a tumor? ☐Yes ☐ No

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

WOMEN: Are you pregnant now? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No

Do you anticipate becoming pregnant? ☐Yes ☐No

Do you:

(a) have breast implants? ☐Yes ☐No

(b) require pre-medication? ☐ Yes ☐No

Medical History

5 Have you ever had any of the following medical problems?

Check Appropriate Box For ALL Conditions

Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Artifical Joint
☐	☐	Heart Disease or Attack	☐	☐	Rheumatism
☐	☐	Heart Murmur	☐	☐	Arthritis
☐	☐	Rheumatic Fever	☐	☐	Nervousness
☐	☐	Artificial Heart Valve	☐	☐	AIDS/HIV
☐	☐	Heart Pacemaker	☐	☐	Bruise Easily
☐	☐	Hepatitis	☐	☐	Emphysema
☐	☐	Cancer Treatment	☐	☐	Asthma
☐	☐	Glaucoma	☐	☐	Cough
☐	☐	Pain in Jaw Joints	☐	☐	Sinus Trouble
☐	☐	Tuberculosis	☐	☐	Stroke
☐	☐	Yellow Jaundice	☐	☐	Diabetes
☐	☐	Kidney Trouble	☐	☐	Hay Fever
☐	☐	Anemia	☐	☐	Hemophilia
☐	☐	Blood Transfusion	☐	☐	Sickle Cell
☐	☐	Thyroid Disease	☐	☐	Epilepsy or Seizures
☐	☐	Fainting or Dizzy Spells			
☐	☐	Psychiatric Treatment	☐	☐	Cholesterol
☐	☐	Allergic To Latex			
☐	☐	Allergic To Tape			
☐	☐	Allergic To Golds or Metals			

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail.

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or X-rays, as may be deemed necessary by the Doctor of Dentistry in attendance.

I authorize the Dentist to release any information including diagnosis and the records of any treatment or examination to me or my child during the period of such Dental Care to the third party payer's and/or health practioner's.

_____ _____
Date Signature of Patient or Guardian

_____ _____
Date Doctor's Signature