

Medical Information

- 1. Are you having pain or discomfort at this time? YES NO
- 2. Have you been a patient in the hospital during the past two years?..... YES NO
- 3. Have you been under the care of a medical doctor during the past two years?..... YES NO
- 4. Have you taken any medication or drugs during the past two years?..... YES NO
- 5. Are you now taking any medication or drugs? YES NO

Please List: _____

- 6. Do you take Fosamax, Coumadin or Aspirin daily?..... YES NO
- 7. Are you sensitive or allergic to any medication or anesthetics?..... YES NO
- 8. Have you ever taken Phen Fen?..... YES NO

9. Indicate which of the following you have had or have at present. Circle 'yes' or 'no' to each item.

Heart Failure	Yes	No	Artificial Joints (hip, knee, etc)	Yes	No	Hepatitis B (serum).....	Yes	No
Heart Disease /Attack	Yes	No	Kidney Trouble.....	Yes	No	Veneral Disease.....	Yes	No
Angina Pectoris.....	Yes	No	Ulcers.....	Yes	No	A.I.D.S.....	Yes	No
Diabetes.....	Yes	No	Congenital Heart Disease	Yes	No	H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Thyroid Problems.....	Yes	No	Cold Sores/Fever Blisters	Yes	No
High Blood Pressure	Yes	No	Glaucoma.....	Yes	No	Blood Transfusion.....	Yes	No
Arteriosclerosis.....	Yes	No	Cancer.....	Yes	No	Hemophilia.....	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema.....	Yes	No	Anemia.....	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	High Cholesterol.....	Yes	No
Heart Surgery.....	Yes	No	Asthma.....	Yes	No	Liver Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Hay Fever.....	Yes	No	Yellow Jaundice.....	Yes	No
Arthritis.....	Yes	No	Allergies or Hives.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Rheumatism.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medicine...	Yes	No	Radiation Therapy.....	Yes	No	Tumors.....	Yes	No
Drug Addiction.....	Yes	No	Chemotherapy.....	Yes	No	Developmentally Disabled	Yes	No
Stroke.....	Yes	No	Hepatitis A (infectious).....	Yes	No	Allergy to Latex.....	Yes	No

10. Physician's Name _____ Address _____ Phone #: _____

- 11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... YES NO
- 12. Do your ankles swell during the day?..... YES NO
- 13. Do you use more than two pillows to sleep?..... YES NO
- 14. Have you lost or gained more than 10 pounds in the past year?..... YES NO
- 15. Do you ever wake up from sleep and feel short of breath?..... YES NO
- 16. Are you on a special diet?..... YES NO
- 17. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
- 18. Have you ever taken any dietary supplements?..... YES NO
- 19. Do you smoke?..... YES NO

For Women only:

Are you pregnant? Yes No What month? _____ Are you nursing? Yes No Are you 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 truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent:

- 1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
- 2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to us the appropriate medication thereby indicated for such treatment in connection with (name of patient) _____.

I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed to provide the recommended treatment.

Patient: _____ Date: _____ Witness: _____
 Parent or Responsible Party: _____ Relationship to Patient: _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

Notes: _____

