PATIENT HEALTH HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Circle **Yes** or **No**.

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Are you taking any medicine? Yes No or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes No
   If so, what? _____
   _____
   _____
7. Are you taking or have you ever taken any osteoporosis medication (Fosamax, Actenol, etc.)? ..... Yes No
8. Do you have a family history of cardio vascular disease? ..... Yes No
9. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... Yes No
10. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Other Yes No
    If Other, what drugs? _____
11. Do you have or have you had any of the following: (**Please check ✓ known conditions.**) ..... Yes No

☐ Anemia	☐ Cold Sores	☐ Sinus Trouble	☐ Blood Transfusions	☐ Pain in Jaw Joints	☐ X-Ray or Cobalt
☐ Herpes	☐ Hemophilia	☐ Blood Disease	☐ Joint Replacement	☐ Respiratory Disease	☐ Fainting Spells or Seizures
☐ Stroke	☐ Rheumatism	☐ Drug Addiction	☐ Nervous Disorders	☐ Sickle Cell Disease	☐ Chemotherapy (Cancer, Leukemia)
☐ Ulcers	☐ Heart Murmur	☐ Kidney Disease	☐ Tumors or Growths	☐ Tuberculosis (T.B.)	☐ Radiation Treatment of any kind
☐ Diabetes	☐ Bruise Easily	☐ Stomach Ulcers	☐ Allergies or Hives	☐ Epilepsy or Seizures	☐ Hepatitis or Jaundice
☐ Glaucoma	☐ Head Injuries	☐ Angina Pectoris	☐ Cortisone Medicine	☐ Artificial Prosthesis	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Arthritis	☐ Heart Failure	☐ Snoring or Sleep Apnea	☐ Excessive Bleeding	☐ Psychiatric Treatment	☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Emphysema	☐ Liver Disease	☐ Rheumatic Fever	☐ Asthma	☐ Congenital Heart Lesions	☐ Metal Allergies
☐ Hay Fever	☐ Scarlet Fever	☐ Thyroid Disease	☐ High Blood Pressure	☐ Difficulty in Swallowing	☐ Hearing Impaired
☐ Tonsillitis	☐ Chicken Pox	☐ Cerebral Palsy	☐ HIV Positive	☐ Heart Ailments or Attack	☐ Latex Allergy ☐ Other_____

12. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
13. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No
    If so, what? _____
14. Do you smoke? If yes, how much? _____ per day ..... Yes No
15. Have you ever taken diet pills by the name of Fen Phen or Redux? ..... Yes No
16. Do you have a history of drug or alcohol abuse? ..... Yes No
17. (Women) Is there a possibility you may be pregnant? ..... Yes No
18. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
19. (Women) Do you take birth control pills? ..... Yes No

DENTAL HISTORY

1. Previous Dentist _____
2. Have you been having any specific problem? ..... Yes No
   Explain _____
3. Does dental treatment make you nervous? ..... Yes No
   If so: ☐ Slightly ☐ Moderately ☐ Severely
4. Do you have or have you had any of the following? ..... Yes No
   ☐ Bad Breath ☐ Loosening of Teeth ☐ Headaches ☐ Bleeding Gums ☐ Sensitive Teeth ☐ Jaws "Pop" or "Lock" ☐ Sinus Trouble
5. Have you ever had any of the following: ☐ Injury ☐ Oral Surgery (teeth removal) ☐ Orthodontics (braces) ☐ Periodontics (gum/graft surgery)
   Explain: _____
6. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
7. Have you ever had any serious trouble associated with any previous dental treatment? ..... Yes No
8. How long since your last dental x-rays? _____
9. How long since your last dental treatment? _____
10. Would you desire to be pre-sedated? ☐ Nitrous Oxide ☐ Drugs ☐ or _____

Yes No

11. It is our intention to make your visit as comfortable as possible. Please comment on how we may further this for you? _____
    _____
12. If you could change your smile, what would you do? _____
    _____

PATIENT
Signature_____ Date_____

DENTIST
Signature_____ Date_____

CONSENT

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided to be necessary or advisable, and to the use of local anesthetic and/or nitrous oxide as may be deemed advisable by the dentist. I have been informed of the various treatment alternatives that relate to my oral condition and their respective advantages, disadvantages, risks, and costs. I hereby authorize my dentist to release any and all medical and dental information to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

PATIENT
Signature_____ Date_____

RESPONSIBLE PARTY
Signature_____ Date_____