MEDICAL HISTORY **NAME:** ____________________

PLEASE ANSWER EACH QUESTION. CIRCLE YES OR NO WHERE APPLICABLE.

1. ARE YOU IN GOOD HEALTH? .... YES NO

2. HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR OPERATION? .... YES NO

   IF YES, WHAT ILLNESS OR OPERATION? ____________________

3. ARE YOU UNDER CONTINUING CARE OF A PHYSICIAN? .... YES NO

   IF YES, WHAT IS THE CONDITION BEING TREATED? ____________________

4. DO YOU SMOKE? .... YES NO 5. DO YOU CHEW TOBACCO? .... YES NO

6. ARE YOU TAKING ANY MEDICATION? .... YES NO

   PLEASE LIST OR PROVIDE LIST ____________________

   ____

7. ARE YOU ALLERGIC OR HAVE YOU EVER HAD A REACTION TO ANY DRUGS? .... YES NO

   ___ PENICILLIN / ANTIBIOTICS ___ CODEINE ___ ANESTHETIC OTHER ____________________

8. (WOMEN) IF PREGNANT, DUE DATE? __________ 9. ARE YOU TAKING BIRTH CONTROL PILLS?.......... YES NO

10. DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

ALLERGIES / HAY FEVER	☐ YES	☐ NO	GLAUCOMA / RETINAL DISEASE	☐ YES	☐ NO	JAUNDICE / LIVER DISEASE	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO	HEAD INJURIES	☐ YES	☐ NO	JOINT REPLACEMENT YEAR___	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO	HEARING IMPAIRMENT	☐ YES	☐ NO	KIDNEY DISEASE	☐ YES	☐ NO
BLOOD DISEASE	☐ YES	☐ NO	HEART CONDITION / AILMENT	☐ YES	☐ NO	LATEX ALLERGY	☐ YES	☐ NO
CANCER	☐ YES	☐ NO	MITRAL VALVE PROLAPSE	☐ YES	☐ NO	RADIATION TREATMENT	☐ YES	☐ NO
DIABETES: TYPE ___	☐ YES	☐ NO	PACEMAKER	☐ YES	☐ NO	RESPIRATORY DISEASE	☐ YES	☐ NO
EPILEPSY / SEIZURES	☐ YES	☐ NO	HEPATITIS: TYPE ___	☐ YES	☐ NO	ARTHRITIS	☐ YES	☐ NO
EXCESSIVE BLEEDING	☐ YES	☐ NO	HIGH BLOOD PRESSURE	☐ YES	☐ NO	SINUS PROBLEMS	☐ YES	☐ NO
FAINTING SPELLS	☐ YES	☐ NO	HIV POSITIVE	☐ YES	☐ NO	STOMACH ULCERS	☐ YES	☐ NO
FEVER BLISTERS	☐ YES	☐ NO						

11. DO YOU HAVE ANY DISEASE OR CONDITION THAT IS NOT COVERED IN THIS MEDICAL HISTORY? .... YES NO

   IF YES, PLEASE EXPLAIN ____________________

NAME OF FORMER DENTIST ____________________ PHONE __________

NAME OF PHYSICIAN ____________________ PHONE __________

ADDRESS ____________________ CITY __________ STATE __________ ZIP CODE __________

PHARMACY NAME ____________________ PHONE __________

PERSON TO CONTACT IN CASE OF EMERGENCY __________ RELATIONSHIP __________ PHONE __________

CONSENT FOR TREATMENT

I HEREBY GRANT TO THE DENTIST IN CHARGE THE AUTHORITY TO ADMINISTER DENTAL TREATMENT, WHICH INCLUDES ANESTHETICS, ANALGESICS AND SEDATIVES DEEMED NECESSARY AND/OR ADVISABLE, AND TO PERFORM THE NECESSARY TREATMENT.

SIGNED ____________________ **DATE** __________

CONSENT MUST BE SIGNED BY PATIENT, PARENT OR LEGAL GUARDIAN.

MEDICAL HISTORY UPDATE

SIGNED ____________________ DATE __________ SIGNED ____________________ DATE __________

REVIEWED BY:

STAFF SIGNATURE: ____________________ DATE __________ STAFF SIGNATURE: ____________________ DATE __________

PLEASE COMPLETE REVERSE