MEDICAL HISTORY

	YES	NO	If yes, explain:
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐	
Are you under a PHYSICIAN'S CARE now?	☐	☐	
Are you currently taking any medication?	☐	☐	

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Drug Addiction	☐	☐	HPV	☐	☐	Rheumatism	☐	☐
Allergies (Seasonal)	☐	☐	Emphysema	☐	☐	(Human Papilloma Virus)			Scarlet Fever	☐	☐
Anemia	☐	☐	Epilepsy	☐	☐	Jaundice	☐	☐	Seizures	☐	☐
Angina (Chest Pain)	☐	☐	Excessive Bleeding	☐	☐	Jaw Joint Pain	☐	☐	Sinus Problems	☐	☐
Arthritis	☐	☐	Fainting	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Heart Conditions	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Lesions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	(Congenital)			Nervousness/	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Depression			Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pacemaker	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Pregnant Currently	☐	☐			
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Radiation (head/neck)	☐	☐			
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Respiratory	☐	☐			
Diabetes	☐	☐	High Blood Pressure	☐	☐	Problems					
Dizziness	☐	☐	HIV Positive	☐	☐	Rheumatic Fever	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO	
Aspirin	☐	☐	Latex	☐	☐	Erythromycin	☐	☐	Other _____
Darvon	☐	☐	Local Anesthetic	☐	☐	Valium	☐	☐	
Nitrous Oxide	☐	☐	Tetracycline	☐	☐	Penicillin	☐	☐	
Percodan	☐	☐	Codeine	☐	☐	Sulfa	☐	☐	

Have you ever taken any the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Actonel	☐	☐	Fosomax	☐	☐	Zometa	☐	☐	Herbal Supplements	☐	☐
Aredia	☐	☐	Reclast	☐	☐	Boniva	☐	☐			

Do you smoke or use chewing tobacco? YES ☐ NO ☐

How much? _____

For how long? _____

Do you drink alcohol? YES ☐ NO ☐

How much/How often? _____

For how long? _____

FAMILY PHYSICIAN _____ **PHONE NO.** _____

Is there any other Medical or Dental information that you feel we should know about? _____

CONSENT:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child) _____ **Date** _____ **Doctor Signature** _____