Patient Medical History

Name____Date____________________

Physician's Name________________________________Date____________________

Check if you are under medical treatment now.

If checked, what for?____

Check if you are or have ever been hospitalized for any surgical procedure or serious illness.

Check if you are taking any medication(s) including non-prescription.

If checked, what medication(s) or supplements) are you taking?________________________________

Check if you use tobacco.

Check if you use alcohol.

Check if you use recreational drugs. If checked, which types?________________________________

Are you allergic to or have you had any reaction to the following? Check all that apply.

Topical Anesthetics	Tylenol	Penicillin
Local Anesthetics	Ibuprofen (Advil)	Sedatives
Latex	Prescription Pain Medications	
Aspirin	Sulfa Drugs	

Other:____

Do you or have you had any of the following? Check all that apply.

AIDS/HIV	COPD	Leukemia
Anemia	Diabetes Type I or II	Liver Disease
Angina	Edema	Mental Illness____________
Arthritis	Emphysema	Osteoporosis
Asthma	Epilepsy	Pacemaker
Autoimmune Disorder________	Fainting	Radiation
Blood Pressure - High	Frequently Tired	Area________________
Blood Pressure - Low	Glaucoma	Year________________
Blood Thinners	Hay Fever	Restless Leg Syndrome
Cancer	Heart Attack	Rheumatic Fever
Area________________	Heart Disease	Stroke
Year________________	Heart Murmur	Thyroid Disorder
Chest Pains	Hepatitis Type A / B / C	Tuberculosis
Cold Sores	Joint Replacement	Ulcers
Convulsions	Kidney Disease	Weight Loss

Other:____

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Women Only. Check if you are:

- Pregnant
- Nursing
- Taking birth control pills

Patient Consent Agreement

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health. I hereby authorize and request the performance of dental services for myself and/or for:

Name____

I authorize and give consent to perform dental services agreed upon between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated.

Patient or Guardian Signature______________________________Date________________

Reviewed and updated______________________________Date________________

Reviewed and updated______________________________Date________________

Reviewed and updated______________________________Date________________

Reviewed and updated______________________________Date________________

Reviewed and updated______________________________Date________________

Reviewed and updated______________________________Date________________