Medical History

Name of Medical Doctor _____

List of medications you are currently taking _____

_____

1. Date of last physical examination _____
2. Are you now under the care of a physician? ..... ☐ Yes ☐ No
   If so, what is the condition being treated? _____
3. Have you ever had any serious illnesses or operations? ..... ☐ Yes ☐ No
   If so, what illness or operation? _____
4. Do you have a heart murmur? ..... ☐ Yes ☐ No
5. Do you have an artificial heart valve? ..... ☐ Yes ☐ No
6. Have you ever had a joint replacement surgery? ..... ☐ Yes ☐ No
7. Have ever been pre-medicated with antibiotics for your dental treatment? ..... ☐ Yes ☐ No
8. Are you sensitive or allergic to any drugs? ☐ Penicillin, ☐ Tetracycline, ☐ Sulfa Drugs, ☐ Aspirin, ☐ Codeine
   ☐ Other If other, what drugs? _____
9. Check (✓) any of the following which you have ever had or have at present:

☐ Heart Failure	☐ Artificial Joint	☐ Sinus Trouble	☐ AIDS	☐ Genital Herpes
☐ Heart Disease or Attack	☐ Anemia	☐ Allergies or Hives	☐ Hepatitis B (serum)	☐ Epilepsy or Seizures
☐ Angina Pectoris	☐ Stroke	☐ Diabetes	☐ Hepatitis C	☐ Fainting or Dizzy Spells
☐ High Blood Pressure	☐ Kidney Trouble	☐ Thyroid Disease	☐ Liver Disease	☐ Nervousness
☐ Heart Murmur	☐ Ulcers	☐ X-ray or cobalt Treatment	☐ Yellow Jaundice	☐ Psychiatric Treatment
☐ Rheumatic Fever	☐ Latex Allergy	☐ Chemotherapy (Cancer, Leukemia)	☐ Blood Transfusion	☐ Sickle Cell Disease
☐ Congenital Heart Lesions	☐ Emphysema	☐ Arthritis	☐ Drug Addiction	☐ Bruise Easily
☐ Scarlet Fever	☐ Cough	☐ Rheumatism	☐ Hemophilia	☐ Fen-Phen
☐ Artificial Heart Valve	☐ Tuberculosis (TB)	☐ Glaucoma	☐ Venereal Disease (Syphilis, Gonorrhea)	
☐ Heart Pacemaker	☐ Asthma	☐ Pain in Jaw Joints	☐ Cold Sores	
☐ Heart Surgery	☐ Hay Fever			

10. Do you wear a cardiac pacemaker or have you had heart surgery? ..... ☐ Yes ☐ No
11. Do you have any disease, condition or problem not listed that you think we should know about? ..... ☐ Yes ☐ No
12. Do you smoke? ..... ☐ Yes ☐ No
    If so, how much? ☐ Cigarettes ____ pack(s) per day ☐ Cigars ____ per day
13. (*Women*) Are you pregnant? ..... ☐ Yes ☐ No
    If so, how many months? _____ mos.
14. (*Women*) Do you have any problems associated with your menstrual period? ..... ☐ Yes ☐ No
15. (*Women*) Do you take birth control pills? ..... ☐ Yes ☐ No

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health History form, to administer such anesthetics, analgesics and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date _____

Signature of Patient, Parent or Guardian

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signed _____ Date _____

Signature of Patient, Parent or Guardian

Signed _____ Date _____

Signature of Patient, Parent or Guardian

Signed _____ Date _____

Signature of Patient, Parent or Guardian