

Patient Name: _____

MEDICAL HISTORY

Do you have any current health problems? Yes No

Please describe _____

Are you currently under the care of a physician? Yes No

Please describe _____

Physician's name and phone _____

Are you currently taking any medications or supplements? Yes No

Medication _____ dose _____

Medication _____ dose _____

Medication _____ dose _____

Have you been in the hospital, had a serious illness, or major surgery? Yes No

Have you had any of the following:

Anemia	Emphysema	Heart surgery	Pacemaker
Arthritis	Epilepsy, Seizures	Hemophilia	Pain in jaw joints
Artificial joints (hip, knee)	Fainting, dizziness	Hepatitis (type__)	Radiation treatment
Asthma	Fever blisters	High blood pressure	Sinus problems
Blood disorders	(cold sores)	Low blood pressure	Sleeping problems (sleep apnea)
Cancer	Glaucoma	HIV-AIDS	Stroke
Chemotherapy	Hay fever	Kidney disease	Tuberculosis
Diabetes	Headaches	Liver disease	Ulcers
Digestive disorders (gastric reflux)	Heart attack	Neurologic problems	
Drug Dependency	Heart disease	Nervousness	
	Heart murmur	Osteoporosis, osteopenia	

Are you allergic to or reacted adversely to any of the following:

Any metals	Erythromycin	Local anesthetic
Aspirin	Ibuprofen	Nitrous oxide
Codeine	Latex	Penicillin

Are you aware of being allergic to any other medications or substances? _____

Any other medical or dental information you feel we should know? _____

The undersigned authorizes the dentist to take necessary x-rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis. I also authorize the dentist to perform all forms of treatment that may be indicated. I understand there are certain risks with the use of anesthetic agents, and I understand that I am responsible for payment of dental services for me and my dependents. I will also assign insurance benefits to the dentist.

Patient signature _____ Date _____