**MEDICAL HISTORY**

 Provider Review

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

The answers to these questions will help us provide you with safe and effective dental care. Answer the following

as accurately as possible. All information is kept confidential.

Please Circle: Y = Yes N = No

1. Do you have a toothache now? . . . . . . . Y / N

2. Have you received medical care

 in the past two years? . . . . . . . . . . . Y / N

3. Have you ever been hospitalized? . . . . . Y / N

4. Have you taken medication in the

 last two (2) months? . . . . . . . . . . . . Y / N

5. Are you allergic to or made sick by

 any medicine such as penicillin,

 aspirin, or codeine? . . . . . . . . . . . . . .Y / N

6. Have you ever had a bleeding problem

 that needed medical treatment? . . . Y / N

7. Do you ever have chest pains? . . . . . . . . Y / N

8. Do you use alcohol? . . . . . . . . . . . . . . . . Y / N

 Ounces per week . . . . . . . . . . . . . .

9. Do you use other drugs? . . . . . . . . . . . . .Y / N

10. Do you use tobacco products? . . . . . . . . Y / N

11. Do you have reason to believe you have

 been exposed to AIDS or HIV? . . . . Y / N

**FEMALES ONLY** – Are you:

Pregnant . . . . . . . . . . . . . . . . Y / N / DON’T KNOW

Taking birth control pills . . . Y / N

Nursing . . . . . . . . . . . . . . . . . Y / N

Have you ever had?

12. Hepatitis . . . . . . . . . . . . . . . . . Y / N

13. Heart murmur . . . . . . . . . . . . . Y / N

14 . Heart attack . . . . . . . . . . . . . . Y / N

15. High blood pressure . . . . . . . . Y / N

16. Rheumatic fever . . . . . . . . . . . Y / N

17. Artificial heart valve or

 pacemaker . . . . . . . . . . . . Y / N

18. Mitral Valve Prolapse . . . . . . . Y / N

19. Anemia . . . . . . . . . . . . . . . . . . Y / N

20. Stroke . . . . . . . . . . . . . . . . . . . .Y / N

21. Ulcers . . . . . . . . . . . . . . . . . . . Y / N

22. Artificial Joint . . . . . . . . . . . . . Y / N

23. Asthma . . . . . . . . . . . . . . . . . . Y / N

24. Sinus trouble . . . . . . . . . . . . . . Y / N

25. Diabetes . . . . . . . . . . . . . . . . . .Y / N

26. Cancer or tumors . . . . . . . . . . .Y / N

27. Epilepsy or seizures . . . . . . . . . Y / N

28. Arthritis/Rheumatism . . . . . . . Y / N

29. Blood transfusions . . . . . . . . . . Y / N

30. Kidney problems . . . . . . . . . . . Y / N

31. Liver problems . . . . . . . . . . . . . Y / N

32. Sexually transmitted

 Disease (VD) . . . . . . . . . . . Y / N

Do you have any disease, condition, or problem not listed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have concerns about receiving dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments (Dental Staff) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 General Consent to Diagnosis and Treatment

I understand there are risks involved in any dental treatment including adverse anesthetic reactions, minor cuts, soft tissue injury, soft tissue infection and swallowing or aspirating objects. Furthermore, I agree to notify my doctor of any changes in this medical history. I give my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns, local anesthesia, roots canals, oral surgery and treatment for gum disease by signing below.

Patient’s or Parent’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_