MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient's Name _____

Are you under a physician's care now?	Yes	No	If yes,_____
Have you ever been hospitalized or had major surgery?	Yes	No	If yes,_____
Have you ever had a serious neck or head injury?	Yes	No	If yes,_____
Are you taking any medications, pills, or drugs?	Yes	No	If yes,_____
Do you take, or have you taken, Phen-fen or Redux?	Yes	No	Do you use tobacco? Yes No
Are you on a special diet?	Yes	No	Controlled Substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur*	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve*	Drug Addiction	Heart Pace Maker*	Mitral Valve Prolapse*	Stroke
Artificial Joint*	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No N/A_____

INFORMED CONSENT

I am the patient or parent/legal guardian authorized to furnish the information requested. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes that may occur in my medical status. I understand that payment for professional services are my (or patient's) sole responsibility and are due as services are rendered. Non payment for services may result in additional collection fees. We do not render services on the basis that insurance companies will pay our fees, but we will be happy to assist you in filing claims for your insurance reimbursement.

I authorize Dr. Thompson to diagnose and provide dental treatment for myself (or patient) including any necessary x-rays or photographs.

Print Name _____ Signature _____ Date _____