

MEDICAL HISTORY

Patient Name: _____

Name of personal Physician: _____ **Last Visit:** _____ **Phone:** _____

Former Dentist: _____ **Last Xrays:** _____ **Phone:** _____

Have you had any serious health problems or surgeries in the last five years? yes no **If yes explain:** _____

(For Women) Are your currently pregnant? yes no **If yes, how many months?** _____

Please list prescription, over the counter medications and vitamin/herbal supplements: _____

Please check if you're allergic to any of the following:

- | | | |
|---|-------------------------------|--------------------------|
| Local anesthetics | Sulfa drugs | Codeine/ other narcotics |
| Penicillin/ other antibiotics | Aspirin | Latex sensitivity |
| Barbiturates, sedatives, sleeping pills | Shellfish, iodine or red wine | Other _____ |

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

- | | | | |
|---------------------------------|--------------------------------|----------------------------|-------------------------|
| Y N AIDS/HIV Positive | Y N Drug Addiction | Y N Hepatitis B or C | Y N Rheumatism |
| Y N Allergies/Hives | Y N Easily Winded | Y N Herpes | Y N Scarlet Fever |
| Y N Allergies to Metals | Y N Emphysema | Y N High Blood Pressure | Y N Shingles |
| Y N Anaphylaxis | Y N Epilepsy or Seizures | Y N Hives or Rash | Y N Sickle Cell Disease |
| Y N Artificial Heart Valve | Y N Excessive Bleeding | Y N Hypoglycemia | Y N Sinus Trouble |
| Y N Arthritis/Gout | Y N Excessive Thirst | Y N Irregular Heartbeat | Y N Spina Bifida |
| Y N Artificial Joint/Prosthesis | Y N Fainting Spells/ Dizziness | Y N Kidney Problems | Y N Stomach Problems |
| Y N Blood Disease | Y N Frequent Cough | Y N Leukemia | Y N Stroke |
| Y N Blood Transfusion | Y N Frequent Diarrhea | Y N Liver Disease | Y N Swelling of Limbs |
| Y N Breathing Problems | Y N Frequent Headaches | Y N Low Blood Pressure | Y N Thyroid Disease |
| Y N Bruise Easily | Y N Genital Herpes | Y N Lung Disease | Y N Tonsillitis |
| Y N Cancer | Y N Glaucoma | Y N Mitral Valve Prolapse | Y N Tuberculosis |
| Y N Cerebral Palsy | Y N Hay Fever | Y N Mental Disorder | Y N Tumors or Growths |
| Y N Chemotherapy | Y N Head Injury | Y N Nervous Disorder | Y N TMJ |
| Y N Chest Pains | Y N Heart Attack/ Failure | Y N Pain in the Jaw Joints | Y N Ulcers |
| Y N Chicken Pox | Y N Heart Murmur | Y N Parathyroid Disease | Y N Venereal Disease |
| Y N Cold sores/ Fever Blister | Y N Heart Pace Maker | Y N Psychiatric Care | Y N Yellow Jaundice |
| Y N Congenital Heart Disorder | Y N Heart Trouble/ Disease | Y N Radiation Treatments | Y N Diabetes |
| Y N Convulsions | Y N Hemophilia | Y N Recent Weight Loss | Y N Osteoporosis |
| Y N Cortisone Medicine | Y N Hepatitis A | Y N Renal Dialysis | Y N Tobacco Use |

Do you take or have you ever taken Bisphosphonates (Fosomax, Boniva etc.) for Osteoporosis or any other condition?

Yes/No If yes, please explain: _____

Have you ever had any serious illness not listed above? Yes/No **If yes, please explain:** _____

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

A. **Date** _____ **Signature** _____

- B. Update – Since your last visit:
- a. Have you seen a medical doctor? _____ yes no
 - b. Have you had a change in your medication? _____ yes no
 - c. Have you had a change in you medical condition? ___ yes no

B. **Date** _____ **Signature** _____

- C. Update – Since your last visit:
- d. Have you seen a medical doctor? _____ yes no
 - e. Have you had a change in your medication? _____ yes no
 - f. Have you had a change in you medical condition? ___ yes no

C. **Date** _____ **Signature** _____

<p>Reviewed By</p> <p>A. _____</p> <p>Date: _____</p> <p>B. _____</p> <p>Date: _____</p> <p>C. _____</p> <p>Date: _____</p>

CONSENT FOR TREATMENT: I hereby grant authority to Dr. James Clark to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedure, anesthetics and or drugs.

Signed: _____ **Date:** _____ **Relationship to Patient:** _____