MEDICAL HISTORY

Patient Name: _____ Date: _____

Physicians Name: _____ Phone Number: _____

1. Are you currently under the care of a physician? Please circle Yes or No

   Please explain: _____

2. Are you allergic to any of the following: **Y / N** Dental Anesthetics **Y / N** Aspirin **Y / N** Erythromycin

   Y / N Tetracycline **Y / N** Latex **Y / N** Codeine **Y / N** Penicillin

3. Do you have any other allergies? _____

Please circle Y or N and specific item as it applies to you

Y/N Heart attack, Heart Trouble, Angina_____
Y/N Prolapsed Mitral Valve/Heart Murmur _____
Y/N Artificial Heart Valve_____
Y/N Liver Disease/Hepatitis_____
Y/N Shingles/Herpes/Fever Blisters_____
Y/N Glaucoma/Eye Surgeries_____
Y/N Epilepsy/Seizures/Fainting spells_____
Y/N Psychiatric Care_____
Y/N Kidney Trouble_____
Y/N Substance Abuse_____
Y/N Diabetes _____
Y/N Heart surgery_____
Y/N Heart stent_____
Y/N Smoker_____
Y/N Allergies/Hives/Skin Rash_____
Y/N Latex Allergy_____
Y/N High Blood Pressure_____

Y/N Heart condition you were born with_____
Y/N Pace Maker / Defibrillator_____
Y/N Rheumatic Fever / Scarlet Fever_____
Y/N Blood Disease/Transfusion_____
Y/N Excessive Bleeding or hemophilia_____
Y/N Anemia/Easy Bruising_____
Y/N Stroke_____
Y/N Asthma_____
Y/N Persistant Cough/Sinus Problems_____
Y/N Tuberculosis/Emphysema_____
Y/N Cancer Treatment/Radiation Therapy_____
Y/N Ulcers/Gastritis/Colitis/Hernia_____
Y/N Arthritis_____
Y/N Artificial Joints anywhere in your body_____
Y/N Venereal Disease_____
Y/N AIDS/HIV infections_____

4. Have you ever been diagnosed with sleep apnea?_____

5. Have you ever had an overnight sleep study?_____

6. Do you or have you used a CPAP?_____

7. Do you wake in the morning with headaches?_____

8. Have you been told that you gasp for air or suddenly stop breathing while sleeping?_____

9. Do you snore or been told that you snore?_____

10. Have you ever had any complications following dental treatment? Yes or No If yes please explain_____

_____

11. Have you been admitted to a hospital or needed emergency care during the past two years?_____

_____

12. Please list any past surgery: _____

_____

13. Please list your medications:_____

_____

14. Is there anything else we should know about your health? _____

Women only:
Y / N Currently pregnant Y / N Nursing Y / N Female problems
Week #: _____ Are you taking birth control pills? _____

*****SEVERAL STUDIES HAVE SHOWN THAT TAKING THE FOLLOWING MEDICATIONS MAY REDUCE THE EFFECTIVENESS OF YOUR BIRTH CONTROL PILLS: ANTIBIOTICS - SULFA DRUGS – PAIN KILLERS – TRANQUILIZERS – SEDATIVES – ANTIHISTAMINES.**

CONSENT FOR SERVICES

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

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis. I consent to the taking of photographs and x-rays before, during, and after treatment, as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for these photographs, x-rays and records to be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phonebooks, television), and publication in professional journals. I further understand that if the photographs, x-rays, and records are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.
I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I am responsible for payment of all services rendered on my behalf or my dependents.

Sign here to verify: _____ _____
Signature (parent or guardian if patient is a minor) **Date**

MEDICAL HISTORY UPDATE

I have reviewed the attached medical history; my health and medications have changed as follows: (if no change, please write "no change".)

Date: _____ BP:_____ Staff Sig:_____

Patient Signature: _____ Date: _____

Date: _____ BP:_____ Staff Sig:_____

Patient Signature: _____ Date: _____

Date: _____ BP:_____ Staff Sig:_____

Patient Signature: _____ Date: _____