

Medical History: If unsure of a question, please consult with your provider.

1. Are you being treated for any medical condition at present or within the past two years?

If yes, please explain: _____

2. Have you been hospitalized in the past two years? If yes, please explain: _____

3. Have you recently, or are presently, taking any **prescription** or **non-prescription** drugs including **herbal** remedies?

4. Do you have any **allergies to medications**? **Other allergies (latex or metal)**? Please List.

5. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction?

Yes No If yes, please explain: _____

6. Do you bleed over 5 minutes when cut? Do you bruise easily? Yes No

If yes, please explain: _____

7. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?

Yes No If yes, please explain: _____

8. Do you have any hearing difficulties? Yes No If yes, please explain: _____

9. Do you smoke or use any other forms of tobacco? Yes No If yes, please explain: _____

Women:

- Are you Pregnant? Yes No
- Do you take Birth Control Pills? Yes No
- Do you take a hormone supplement? Yes No

10. Indicate which of the following you presently have or have ever had:

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Lupus | <input type="checkbox"/> Scarlet → |
| <input type="checkbox"/> Arthritis/ rheumatism | <input type="checkbox"/> Fainting or Dizzy spells | <input type="checkbox"/> Herpes (cold sores) | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Mental/nervous disorder | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Artificial joints (hips, knee) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hodgkin's disease | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stomach/ intestinal problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hyper (hypo) glycemia | <input type="checkbox"/> Medical implant | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy /Radiation | <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> IBS / Crohn's | <input type="checkbox"/> Heart rhythm disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Thyroid disease |
| | | | | <input type="checkbox"/> Tuberculosis |

11. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?

Yes No If yes, please tell us about it _____

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive any questions regarding my medical – dental history. Should there be any change in either my health status or any other information I have provided, I will advise the dental hygienist. I authorize the provider to perform dental hygiene diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____
Signature - Client/Parent/Guardian (Print Name of Guardian)

Reviewed by RDH: _____ Date: _____