

## MEDICAL HISTORY

Family Physician

Phone

Are you under the care of a physician:

☒ Yes ☐ No

If yes, please explain:

Have you had a major operation?

☒ Yes ☒ No

If yes, please describe:

Do you have any health problems that need further clarification?

☐ Yes ☒ No

If yes, please explain:

Have you ever had any complications following dental treatment?

☐ Yes ☒ No

If yes, please describe:

Do you now or have you ever had any of the following? (check all that apply)

Anemia	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hepatitis A/B/C	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	High or Low Blood Pressure	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Artificial Bones/Joints	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Joint Replacement (hip, knee, etc.)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Blood Disorder	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Lung Disease/Tuberculosis	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Mental Disorder	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Congenital Heart Defect	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Mitral Valve Prolapses	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Frequent Headaches	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Sinus Problem	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	STD	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Stomach/Intestinal Problems	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Head Injuries	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Thyroid Disease - on Synthroid	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Please list any other serious medical conditions you have or had in the past:

Please list any current medication you are taking:

Synthroid 25 ug/day 10 mg/day Crestor

Do you require pre-medications prior to dental treatment?

☐ Yes ☐ No

Are you Allergic to any of the following?

Penicillin	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Sedatives	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Dental Anesthetic	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Erythromycin	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Sulfa Drugs	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Keflex	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Metals	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Latex	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Local Anesthetic	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Other Allergies:

For Women:

Are you taking Birth Control Pills?

☐ Yes ☒ No

Are you Pregnant?

☐ Yes ☒ No

Are you Nursing?

☐ Yes ☒ No

This is to certify that I, [redacted], consent to the performing of the dental and oral surgery procedures agreed to be necessary or advised, including the use of local anesthetics as indicated. I will assume responsibility for fees associated with those procedures including those fees which are not covered by any insurance I may be covered by at any given time. I am aware that I will be charged for any missed appointments and/or appointments cancelled with less than 2 business days' notice. I agree that the information pertaining to my health will be kept confidential at this time.

Date

Oct 13th 2020

Signature

Parent ( )

Guardian ( )