Medical History

Do you have a Primary Care Doctor? Yes / No Name of Doctor:_____

Do you now or ever have one of these conditions? (Check all that apply)

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Allergies/Hay fever
- ☐ Alzheimer's
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer (Specify Below)
- ☐ Chemotherapy
- ☐ Crohn's Disease
- ☐ Circulatory Problems
- ☐ Cold Sores
- ☐ Dental Anxiety
- ☐ Dementia
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Headaches/Migraines
- ☐ Heart Problems (Specify Below)
- ☐ Hepatitis A B C (Circle one)
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Joint Replacement (Specify Below)
- ☐ Kidney Problems (Specify Below)
- ☐ Liver Problems (Specify Below)
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems (Specify Below)
- ☐ Sleep Apnea
- ☐ Special Diet
- ☐ STD (Specify Below)
- ☐ Stroke
- ☐ Thyroid Problems (Specify Below)
- ☐ TMJ
- ☐ Ulcerative Colitis
- ☐ Ulcers

Specifications/Other:_____

List of medications you are currently taking (include birth control):_____

_____

Medication Allergies:_____

Do you need to Pre-Medicate? Yes/No Do you use tobacco in any form? Yes/No

Women only Are you pregnant? Yes/No How many weeks?_____ Are you nursing? Yes/No

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated, I certify to the above statement regarding my medical condition.

Signature:_____ Date:_____

Relationship to patient:_____