## 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 ____________

Reviewed By
A. ____________
Date: ____________
B. ____________
Date: ____________
C. ____________
Date: ____________

**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: ____________