



# MEDICAL HISTORY



Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Pharmacy \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Please check (P) "yes" or "no" to indicate if you have had any of the following:

- AIDS  Yes  No
- Anemia  Yes  No
- Arthritis, Rheumatism  Yes  No
- Asthma  Yes  No
- Back Problems  Yes  No
- Cancer  Yes  No
- Chemical Dependency  Yes  No
- Chemotherapy  Yes  No
- Circulatory Problems  Yes  No
- Cortisone Treatments  Yes  No
- Cough, persistent or bloody  Yes  No
- Diabetes  Yes  No
- Emphysema  Yes  No
- Epilepsy  Yes  No
- Fainting or dizziness  Yes  No
- Glaucoma  Yes  No
- Headaches  Yes  No
- Heart Problems  Yes  No
- Hepatitis Type \_\_\_\_\_  Yes  No
- Herpes  Yes  No

- High Blood Pressure  Yes  No
- HIV Positive  Yes  No
- Jaundice  Yes  No
- Jaw Pain  Yes  No
- Kidney Disease  Yes  No
- Liver Disease  Yes  No
- Low Blood Pressure  Yes  No
- Nervous Problems  Yes  No
- Psychiatric Care  Yes  No
- Radiation Treatment  Yes  No
- Respiratory Disease  Yes  No
- Scarlet Fever  Yes  No
- Shortness of Breath  Yes  No
- Sinus Trouble  Yes  No
- Skin Rash  Yes  No
- Special Diet/Weight Loss  Yes  No
- Stroke  Yes  No
- Swollen Feet or Ankles  Yes  No
- Swollen Neck Glands  Yes  No
- Thyroid Problems  Yes  No

- Tonsillitis  Yes  No
- Tuberculosis  Yes  No
- Tumors or Growths  Yes  No
- Ulcer  Yes  No
- Venereal Disease  Yes  No

Have you ever had or been diagnosed with:

- Artificial Heart Valves  Yes  No
- Artificial Joints, Screws, Pins, etc.  Yes  No
- Bleeding abnormally, with extractions or surgery  Yes  No
- Blood Disease  Yes  No
- Congenital Heart Lesions  Yes  No
- Heart Murmur  Yes  No
- Hernia Repair  Yes  No
- Mitral Valve Prolapse  Yes  No
- Pacemaker  Yes  No
- Rheumatic Fever  Yes  No

Have you ever had any complications following dental treatment?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been hospitalized or do you have any other health concerns?  Yes  No

If yes, please describe \_\_\_\_\_

Women: Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

Have you ever taken any of these medications?

- Blood Thinners  Yes  No
- Coumadin  Yes  No
- Warfarin  Yes  No
- Diet Medications  Yes  No
- Dextenfluramine  Yes  No
- Fen-phen  Yes  No
- Pondimin  Yes  No
- Redux  Yes  No
- Levoxyl  Yes  No
- Synthroid  Yes  No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atevia, Didronel, Boniva.  Yes  No

Are you allergic to:

- Aspirin  Yes  No
- Barbiturates  Yes  No
- Codeine  Yes  No
- Ibuprofen  Yes  No
- Latex  Yes  No
- Local Anesthesia  Yes  No
- Metals (i.e. gold)  Yes  No
- Penicillin  Yes  No

Other \_\_\_\_\_

Please PRINT all medications now taking: \_\_\_\_\_

## SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_ Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. \_\_\_\_\_ to use and/or disclose my Protected Health Information (PHI) related to \_\_\_\_\_ Describe in detail the Protected Health Information  
Name of Doctor Disclosing PHI

\_\_\_\_\_ The information will be used and/or disclosed for the purpose of \_\_\_\_\_ Describe each purpose for which you are authorizing  
you are authorizing to be used and/or disclosed.

\_\_\_\_\_ I authorize Dr. \_\_\_\_\_ to receive and use the information.  
your Protected Health Information to be used and/or disclosed. Name of Doctor Receiving PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

## DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to \_\_\_\_\_ Date \_\_\_\_\_

Results \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_