Patient Medical History

General Health: Good [ ] Fair [ ] Poor [ ]

Physician _____ Office Phone _____ Date of Last Exam _____

Are you currently on any medications? Yes [ ] No [ ] if **"Yes"** please list medications and purpose:

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? Yes [ ] No [ ] if **"Yes"** please circle or list

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Any Metals

_____ _____

Please mark the ones that apply to you and your Medical History.

Y	N	Need antibiotic coverage prior to dental work?	Y	N	Excessive thirst and/or urination?
Y	N	Artificial joint replacement or Implant?	Y	N	Recent unusual weight loss?
Y	N	Undergone Radiation or IV Chemotherapy?	Y	N	Subject to fainting?
Y	N	Use or have used tobacco products?	Y	N	Recently hospitalized or past major surgeries?
Y	N	Subject to prolonged bleeding?	Y	N	**(Women)** Currently pregnant?____ How far?____
Y	N	Family history of Diabetes?	Y	N	**(Women)** Currently nursing?

Please circle Y ***or*** N ***individually for each question:***

Y	N	High or Low Blood Pressure	Y	N	Heart Disease	Y	N	Osteoporosis
Y	N	Heart Attack	Y	N	Cardiac Pace Maker	Y	N	Chest Pains
Y	N	Rheumatic Fever	Y	N	Heart Murmur	Y	N	Long-Term Steroid Treatment
Y	N	Swollen Ankles	Y	N	Artificial Heart Valves	Y	N	Scarlet Fever
Y	N	Fainting / Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis
Y	N	Asthma	Y	N	Anemia	Y	N	Glaucoma
Y	N	Epilepsy / Convulsions	Y	N	Emphysema	Y	N	Liver Disease
Y	N	Leukemia	Y	N	Cancer (type:_____)	Y	N	Hemophilia
Y	N	Diabetes (type:____)(A1C____)	Y	N	Arthritis / Rheumatism	Y	N	Respiratory Problems
Y	N	Kidney Disease	Y	N	Jaundice / Hepatitis (type:____)	Y	N	Mitral Valve Prolapse
Y	N	AIDS / HIV Infection	Y	N	Sexually Transmitted Disease	Y	N	Eating Disorders
Y	N	Thyroid Problem	Y	N	Stomach Troubles / Ulcers	Y	N	Neck or Back Problems

Do you have any other medical or health condition which is not listed? Yes [ ] No [ ] if **"Yes"** please list:

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize Roselle Park Dental to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Signature:_____ Date:_____