

MEDICAL HISTORY

Patient Name _____ Age _____

Physician's Name _____ Physician's Telephone # _____

Are you presently under a Physician's Care? _____ If so, please describe _____

Date of Last Physical _____

Are you presently taking any medication? _____ If so, please list _____

Serious Illness or operation (in last five years) _____

Is there any reason you need to be Pre-Medicated before Dental treatment? _____

What is the estimate of your General Health? _____ Poor _____ Fair _____ Good _____

PLEASE CIRCLE either YES or NO for any of the following which you have had or have:

- | | | |
|--|---|---|
| YES NO Heart Problems | YES NO Asthma | YES NO Smoke or Use Tobacco |
| YES NO Heart Failure/Attack | YES NO Sinus Trouble | YES NO Cold Sores |
| YES NO Angina Pectoris | YES NO Head or Neck Injuries | YES NO Epilepsy/Seizures |
| YES NO High Blood Pressure | YES NO Diabetes | YES NO Fainting/Dizzy Spells |
| YES NO Low Blood Pressure | YES NO Thyroid Disease | YES NO Psychiatric Treatment |
| YES NO Heart Murmur | YES NO Arthritis | YES NO Bruise Easily |
| YES NO Rheumatic Fever | YES NO Rheumatism | |
| YES NO Mitral Valve Prolapse | YES NO Cortisone Medication | Are you Allergic or Sensitive to: |
| YES NO Artificial Heart Valve | YES NO Cancer or Tumor | YES NO Aspirin |
| YES NO Heart Pacemaker | YES NO Radiation Treatment for Cancer/Tumor | YES NO Codeine |
| YES NO Stroke | YES NO Chemotherapy | YES NO Erythromycin |
| YES NO Artificial Joint | YES NO Drug Addiction | YES NO Tetracycline |
| YES NO Kidney Trouble | YES NO Blood Transfusion | YES NO Penicillin/Ampicillin |
| YES NO Liver Trouble | YES NO Hemophilia | YES NO Local Anesthetic
(Xylocaine/Carbocaine) |
| YES NO Ulcers | YES NO Venereal Disease | |
| YES NO Emphysema | YES NO HIV+ | YES NO Latex (gloves) |
| YES NO Tuberculosis (TB) | YES NO AIDS | YES NO Other Substances list |
| YES NO Glaucoma | YES NO Hepatitis (Type _____) | _____ |
| YES NO Do you ever have pain in chest, shortness of breath, or swollen ankles? | | _____ |
| YES NO Do you have any disease, condition, or problem not listed? _____ | | |

FOR WOMEN ONLY:

YES NO Are you pregnant? If so, what month? _____

YES NO Are you taking birth control pills? _____

CONSENT

I consent to the taking of photographs, necessary x-rays, and study models during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

Upon a diagnosis being made, I authorize Drs. Hall and Hall to perform all recommended treatment mutually agreed upon by me and to employ such assistance and materials as required to provide proper care.

I consent to the use of appropriate medications and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____