



**-Health History-**

To our patients:

Although dentists primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit: \_\_\_\_\_

- |     |   |     |    |
|-----|---|-----|----|
| 10. | Are you in good health? -----   | Yes | No |
| 11. | Have there been any changes in your general health in the past year? -----  | Yes | No |
| 12. | Are you under the care of a physician?----- Date of last visit: _____   | Yes | No |
|     | If so, for what are you being treated? _____  |     |    |
| 13. | Have you had any illness, operation or been hospitalized in the past five years? -----  | Yes | No |
| 14. | Do you have any unhealed injuries, or inflamed areas in or around your mouth, growths or sore spots in your mouth?----- If so, describe where _____ | Yes | No |
| 15. | Do you have a prosthetic joint? ----- If so, describe where _____   | Yes | No |

	<b>Have You Had Or Do You Currently Have-----</b>	Yes	No	Notes		<b>Have You Had Or Do You Currently Have-----</b>	Yes	No	Notes
16.	Rheumatic fever?				43.	Gallbladder trouble?			
17.	Damaged heart valves?				44.	Fainting spells?			
18.	Mitral valve prolapse?				45.	Convulsions / epilepsy?			
19.	Heart murmur?				46.	Stroke?			
20.	High blood pressure?				47.	Thyroid trouble?			
21.	Low blood pressure?				48.	Diabetes?			
22.	Chest pain / angina?				49.	Low blood sugar?			
23.	Heart attack(s)?				50.	Kidney trouble?			
24.	Irregular heart beat?				51.	Are you on dialysis?			
25.	Cardiac pacemaker?				52.	Arthritis / joint disease?			
26.	Heart surgery?				53.	Stomach ulcers?			
27.	Bronchitis, chronic cough?				54.	Contagious diseases?			
28.	Asthma?				55.	Sexually transmitted Disease?			
29.	Hayfever / sinus problems?				56.	Immunosuppressed?			
30.	Tuberculosis?				57.	Delay in healing?			
31.	Emphysema?				58.	Tumor(s) or growth(s)?			
32.	Difficulty breathing?				59.	X-ray Tx. / chemotherapy?			
33.	Any other lung trouble?				60.	Chronic fatigue/Night Sweats?			
34.	Do you smoke?				61.	Are you on a diet?			
35.	Blood transfusion?				62.	A history of drug abuse?			
36.	Blood disorder / anemia?				63.	A history of alcohol abuse?			
37.	Bruise easily?				64.	Contact lenses?			
38.	Abnormal bleeding?				65.	Eye disease / glaucoma?			
39.	Jaundice, hepatitis?				66.	Mental health problems?			
40.	Other liver disease?				67.	A removable dental appliance?			
41.	Infectious mononucleosis?				68.	Pain / clicking of jaws?			

<b>Medications:</b>		
70. Are you now taking any kind of medicine, drug or pills for any purpose?-----	Yes	No
71. Anticoagulants?-----	Yes	No
72. Tranquilizers?-----	Yes	No
73. Cortisone?-----	Yes	No
74. Other medications? (Please list) _____		

<b>Allergies:</b>		
75. Are you allergic to or had a reaction to local anesthetics?-----	Yes	No
76. Penicillin?-----	Yes	No
77. Other antibiotics? Please List:_____	Yes	No
78. Latex, nickel?-----	Yes	No
79. Aspirin?-----	Yes	No
80. Codeine or other narcotics?-----	Yes	No
81. Other medications?-----	Yes	No
82. Allergies other than drug allergies?-----	Yes	No
Please List _____		

<b>Women:</b>		
83. Is there a possibility that you may be pregnant?-----	Yes	No
84. Estimated delivery date?_____		
85. Are you nursing?-----	Yes	No
86. Are you taking birth control pills?-----	Yes	No
<b>WOMEN NOTE:</b> Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your Physician / gynecologist for assistance regarding additional methods of birth control.		

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD?-----	Yes	No
Is there a family history of-----		
87. Cancer-----	Yes	No
88. Heart disease-----	Yes	No
89. Diabetes-----	Yes	No
90. Anesthetic Problems-----	Yes	No
91. Do you have a history of Biphosphonate therapy (i.e. Zometa, Aredia, Fosamax) therapy? -----	Yes	No
92. Do you object to the use of your photographs for educational, research or promotional purposes? -----	Yes	No

I certify that I have read the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

**-CONSENT FOR TREATMENT AND ANESTHESIA-**

The consent and the nature of the dental and / or surgical treatment have been fully explained to me. I have been fully informed of, and understand all the risks to me in the performance of the treatment to be rendered. I understand that there is a possibility of complications developing during or after treatment and these have been explained to me. I have been informed that some possible complications are pain, infection, swelling, bleeding, bruising, temporary or permanent numbness and tingling of the lip, chin, tongue, gums, cheek or teeth, fractured root tips, separated endodontic instruments, trismus (difficulty with opening of the mouth), and unfavorable reactions to drugs and anesthetics. I understand that alternate methods to the proposed procedure(s) as they are available to treat my dental disorder were fully described to me prior to the performance of treatment.

I am now giving my free and voluntary informed consent for the treatment to be rendered. I have not been given or received any guarantee as to the results to be obtained from the treatment I am to receive. I have been told that there will be anesthesia administered (when necessary), as well as the type and nature of such anesthesia, as well as any risks involved in the administration of the anesthesia as well as the anesthesia itself. The above has been fully explained to me, and I do give my free and voluntary informed consent to the same.

I will not use alcohol or take any medications or drugs (other than those prescribed) without first consulting with the doctor.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Patient (Parent or Guardian if Minor)

\_\_\_\_\_ Witness