



## Medical History

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Name of Family Physician \_\_\_\_\_

My current Physical Health is

Good  Fair  Poor

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

(Check yes or no)

Yes No

Ulcers /Colitis ..... \_\_\_\_\_

\*Rheumatic Fever / Artificial Valves/ Murmur ..... \_\_\_\_\_

Heart Disease/ Defect/ Pacemaker ..... \_\_\_\_\_

Mitral Valve Prolapse ..... \_\_\_\_\_

High or low blood pressure ..... \_\_\_\_\_

Kidney problems ..... \_\_\_\_\_

\* Diabetes ..... \_\_\_\_\_

Tuberculosis ..... \_\_\_\_\_

Malignancies (Cancer) ..... \_\_\_\_\_

Asthma ..... \_\_\_\_\_

Hay Fever, Allergies, or Hives ..... \_\_\_\_\_

\* Epilepsy/ Seizures/ Fainting ..... \_\_\_\_\_

\*Liver Disease or Jaundice ..... \_\_\_\_\_

Thyroid Disorder ..... \_\_\_\_\_

Difficulties in Hearing or Vision ..... \_\_\_\_\_

Alcohol/ Drug Abuse ..... \_\_\_\_\_

Cigarettes ..... \_\_\_\_\_

Stroke/TIA's ..... \_\_\_\_\_

Sinus Trouble ..... \_\_\_\_\_

AIDS or HIV infection ..... \_\_\_\_\_

Artificial Joint (Hip or Knee) ..... \_\_\_\_\_

\*Excessive or Prolonged Bleeding/Hemophilia ..... \_\_\_\_\_

\*Anemia or Blood Disorder ..... \_\_\_\_\_

### ADVERSE EFFECTS OR REACTION TO:

\*Penicillin ..... \_\_\_\_\_

\* Local Anesthetic (Novacaine, etc.) ..... \_\_\_\_\_

Any Other Drugs ..... \_\_\_\_\_

Latex ..... \_\_\_\_\_

Are you now or recently been under the care of a physician? ..... \_\_\_\_\_

Are you taking any medicine, prescribed or self-administered? \_\_\_\_\_

Have you ever had radiation treatment or been exposed to a considerable amount of radiation ?

Extent \_\_\_\_\_ When \_\_\_\_\_

### CURRENT MEDICATIONS:

### ADDITIONAL COMMENTS/ HOSPITALIZATIONS:

Are you Pregnant ?  Yes  No

Are you Nursing ?  Yes  No

If yes, what month? \_\_\_\_\_

Are you taking birth control pills?  Yes  No

ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

### CONSENT:

The undersigned hereby authorizes Dr. London to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. London to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with myself or patient and further authorize and consent that Dr. London choose and employ assistance. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Service provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In addition I grant Dr. London the right to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

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



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.