R.L. Daschbach Dentistry & Associates

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_ **Patient Medical History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiologist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiologist’s Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy’s Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Number to Reach You:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle appropriate response:

|  |  |  |  |
| --- | --- | --- | --- |
| Are you under a physician’s care now? | YES | NO | *If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Do you take an anti-coagulant? (a blood thinner) | YES | NO | *If so what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Have you ever taken or received any medications contain bisphosophonates? (ie. Fosamax, Boniva) | YES | NO | *If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Have you taken a phosphodiesterase? (i.e. Viagra, etc)? | YES | NO |  |
| Do you take, or have you taken Phen-Fen? | YES | NO |  |
| Are you on a special diet? | YES | NO | *If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Do you use tobacco? | YES | NO | *How Often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Do you use controlled substances? | YES | NO | *If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

Have you had or have at the present any of the following: (*Please circle option that applies*)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Y | N | Angina Pectoris | Y | N | Hearing Impairment |
| Y | N | Atrial Fibrillation | Y | N | Hemophilia/Abnormal Bleeding |
| Y | N | Alcoholism/Drug Addiction | Y | N | Hepatitis/TYPE\_\_\_\_\_\_ |
| Y | N | Anemia | Y | N | High Blood Pressure |
| Y | N | Artificial Bone/Joint/Valves/Spinal Fusion | Y | N | Liver Disease |
| Y | N | Arthritis/Rheumatoid Arthritis/Lupus | Y | N | Low Blood Pressure |
| Y | N | Asthma/Inhaler | Y | N | HIV+/AIDS |
| Y | N | Anxiety/Mood Disorder | Y | N | Hypoglycemia |
| Y | N | Bacterial Endocarditis | Y | N | Kidney Problems/Renal Dialysis |
| Y | N | Blood Transfusion | Y | N | Mental or Physical Impairment |
| Y | N | Cancer/Chemotherapy/Radiation Treatment  Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N | MRSA |
| Y | N | C-Dif | Y | N | Pins, Plates or Screws |
| Y | N | Congenital Heart Defect | Y | N | Rheumatic Fever/Scarlet Fever |
| Y | N | Diabetes TYPE I or TYPE II | Y | N | Seasonal Allergies/Hay Fever |
| Y | N | Eating Disorders | Y | N | Shingles |
| Y | N | Emphysema/COPD/Difficulty Breathing | Y | N | Sickle Cell Disease/Traits |
| Y | N | Epilepsy/Seizures/Fainting Spells | Y | N | Sinus Problems |
| Y | N | Fever Blisters/Herpes | Y | N | Stomach Problems/Acid Reflux/GERD |
| Y | N | Heart Attack/Stroke/Congestive Heart Failure | Y | N | STD/HPV/other infectious disease |
| Y | N | Heart Murmur/Mitral Valve Prolapse | Y | N | Thyroid Problems/Adrenal Pituitary |
| Y | N | Heart Surgery/Pacemaker | Y | N | Transplant |
|  |  |  | Y | N | Tuberculosis(TB)/When?\_\_\_\_\_\_ |

Women: Are you…

Pregnant/trying to get pregnant? 🞏 YES 🞏 NO Nursing? 🞏 YES 🞏 NO

Do you take birth control pills? 🞏 YES 🞏 NO \* Please be aware that antibiotics can alter effectiveness of birth control

Are you allergic to any of the following? 🞏 YES 🞏 NO

🞏 Aspirin 🞏Penicillin 🞏Codeine 🞏NSAIDS (IBPROPHEN) 🞏Metals 🞏 Sulfa Drugs

🞏Local Anesthetic (Novocaine) 🞏Food Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Other, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Are you taking any medications, herbal supplements or vitamins/minerals? | YES | NO | *Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Please list any surgeries you have had? |  |  | *Please list: (Include Year of surgery) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

Do you have any disease, condition or problem not listed above that you think we should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization & Consent**

I acknowledge that I am responsible for informing the doctor about any changes in my medical status prior to treatment. I understand that providing incorrect information can be dangerous to my (or patients’ health).

I understand that my health history information will be used as necessary for diagnosis or treatment by the doctors. I hereby authorize and request the performance of dental services for:

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINT NAME OF PATIENT**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE**

**I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE**

**Clinician Only:**

**Doctor’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date

Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date Updated: \_\_\_\_\_\_\_\_\_\_\_ Initial/Date