HEALTH HISTORY

CURRENT INFORMATION

Patient Name:______________________________________

Do you have a personal Physician? YES or NO

Physician's Name:__________________________________

Phone #_______________________**Last Visit**_____________

Are you currently under the care of a physician? YES or NO

If yes, Please explain__________________________________

Are you taking any prescription/over-the-counter drugs?

YES or NO Please list each one:____________________

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MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y / N Aids	**Y / N** Excessive Bleeding	**Y / N** Multiple Scleroses
Y / N Allergies (SEE LIST TOP RIGHT)	**Y / N** Fainting	**Y / N** Pacemaker
Y / N Anemia	**Y / N** Fever Blisters	**Y / N** Radiation Treatment
Y / N Arthritis	**Y / N** Glaucoma	**Y / N** Respiratory Problems
Y / N Artificial Joints	**Y / N** Growths	**Y / N** Rheumatic Fever
Y / N Artificial Valves	**Y / N** Hay Fever	**Y / N** Rheumatism
Y / N Asthma	**Y / N** Heart Attack	**Y / N** Sinus Problems
Y / N Blood Disease	**Y / N** Heart Arrhythmia	**Y / N** Stomach Problems
Y / N Cancer	**Y / N** Heart Disease	**Y / N** Stroke
Y / N Cold Sores	**Y / N** High Blood Pressure	**Y / N** Tuberculosis
Y / N Congenial Heart	**Y / N** Kidney Disease	**Y / N** Tumors
Y / N Diabetes	**Y / N** Liver Disease	**Y / N** Ulcers
Y / N Dizziness	**Y / N** Mental Disorders	**Y / N** Venereal Disease
Y / N Drug/Alcohol Abuse	**Y / N** Mitral Value Prolapse	
Y / N Epilepsy		

Please list any serious medical condition(s) that you have ever had which are not on list. ____

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FOR WOMEN

Are you taking birth control? YES or NO

Are you pregnant? YES or NO Week #_________

Are you nursing? YES or NO

ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS?

Y / N Amoxicillin	**Y / N** Darvon	**Y / N** Epinephrine	**Y / N** Nitrous
Y / N Aspirin	**Y / N** Demerol	**Y / N** Ibuprofen	**Y / N** Penicillin
Y / N Ceclor	**Y / N** Dental Anesthetics	**Y / N** Keflex	**Y / N** Sulfa Drugs
Y / N Codeine	**Y / N** Erythromycin	**Y / N** Latex	**Y / N** Tetracycline

Other____

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CURRENT ORAL HEALTH

PLEASE ANSWER ALL OF THE QUESTIONS TO HELP US SERVE YOU TO THE BEST OF OUR ABILITIES

How long ago was your last dental visit?_____________________

Do you have or have you ever had bleeding or sensitive gums?

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Have you ever used or are you now using tobacco or alcohol?

________________________________**Frequency**______________

Please outline your Brushing/Flossing habits__________________

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HEALTH QUESTIONNAIRE ACKNOWLEDGMENT

I CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signed:______________________________Date:_____________

CONSENT TO PROCEED

I authorize Dr. Utley and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative analgesic, (including nitrous oxide,) therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

I do voluntarily assume any and all possible risk, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:____Date:______________

Witness:____Date:______________