Patient Name:_____
Patient Date of Birth:_____
Today's Date:_____

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Do you have, or have you had, any of the following diseases or medical problems?

Bleeding problems	Y	N	High blood pressure	Y	N	By-pass/Valve replacements	Y	N
Low blood pressure	Y	N	Heart attack	Y	N	Heart murmur	Y	N
Other heart problems	Y	N	Stroke	Y	N	Joint replacement	Y	N
Mitral valve prolapse	Y	N	Tumor or cancer	Y	N	Radiation treatment	Y	N
Diabetes	Y	N	Hepatitis	Y	N	Jaundice	Y	N
Kidney Problems	Y	N	Liver problems	Y	N	Arthritis	Y	N
AIDS/HIV	Y	N	Venereal Disease	Y	N	Glaucoma	Y	N
Thyroid problems	Y	N	Epilepsy	Y	N	Lung disease/asthma	Y	N
Psychiatric treatment	Y	N	T. B./Tuberculosis	Y	N	Rheumatic Fever	Y	N
Alcohol/Drug problem	Y	N	Currently pregnant?	Y	N	Periodontal-Gum Surgery	Y	N
TMJ problems	Y	N	Osteoporosis	Y	N	***Complications of dental treatment***	Y	N

If you answered yes to any of the above questions, please explain further:

_____

_____

Are you taking any medications or over the counter drugs? Y N If yes, please list each one:

_____

_____

Are you taking any medications for Osteoporosis? Y N List meds _____

Are you taking any medications to thin your blood? Y N List Meds _ _____

Physician's Name: _____Phone: _____ Date of last visit:_____

Please list any serious medical conditions, hospitalization in the last two years, impending operations, or other medical or dental information that may possibly affect your dental treatment:

_____

_____

Are you allergic to any of the following? Latex Y N Codeine Y N Aspirin Y N

Dental Anesthetics Y N Penicillin Y N Other: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status or personal information. I authorize the dental staff of _Dr. McGuinn Davis, Durand, and Palmer to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize the release of any dental and medical information necessary to process insurance claims or to aide in the treatment by a specialist.

Signature: _____ Date_____