MEDICAL HISTORY

Name of Physician: _____ Office ph#: _____ Date of last exam: _____

Do you currently have of have you ever had any of the following? (please check all that apply)

□ Angina	□ Emphysema	□ Jaundice	□ Respiratory Problems
□ Anemia	□ Fainting/Seizures	□ Kidney Disease	□ Rheumatic Fever
□ Arthritis	□ Frequently Tired	□ Leukemia	□ Sinus Problems
□ Artificial Joints	□ Glaucoma	□ Liver Disease	□ Stroke
□ Asthma	□ Hay Fever	□ Low Blood Pressure	□ Thyroid Problem
□ Bleeding Disorder	□ Head Injuries	□ Mental Disorders	□ Tuberculosis
□ Blood Disease	□ Heart Disease	□ Mitral Valve Prolapse	□ Ulcers
□ Cancer	□ Heart Murmur	□ Nervous Disorders	□ Venereal Disease
□ Chest Pains	□ Hepatitis	□ Pacemaker	□ _____
□ Diabetes	□ High Blood Pressure	□ Radiation Treatment	□ _____
□ Easily Winded	□ HIV/AIDS	□ Recent Weight Loss	□ _____

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□ Yes □ No Are you currently under going medical treatment? If yes, for what? _____

□ Yes □ No Have you been admitted to the hospital or needed emergency care during the past two years? If yes, please explain: _____

□ Yes □ No Are you currently taking medications whether prescription or over-the-counter? If yes, please list below:
_____

□ Yes □ No Do you use tobacco? If yes, what kind and how much? _____

□ Yes □ No Do you drink alcohol? If yes, how much and how often? _____

□ Yes □ No Do you use recreational drugs? If yes, which drugs, how much and how often? _____

□ Yes □ No Have you ever taken Fen-Phen, Redux or any other prescription weight loss drug?

□ Yes □ No Do you wear contacts?

Are you allergic to or have you had an adverse reaction to any of the following? (check all that apply)

□ Local Anesthetics (i.e. Novocain)	□ Barbiturates	□ Aspirin	□ Codeine
□ Penicillin	□ Sedatives	□ Any metals (i.e. nickel)	□ Other:
□ Sulfa Drugs	□ Iodine	□ Latex Rubber	_____

For Women Only:
Are you pregnant? □ Yes □ No Are you taking oral contraceptives? □ Yes □ No Are you nursing? □ Yes □ No

DENTAL HISTORY

Name of Dentist: _____ Date of last exam: _____ Reason for this visit: _____

□ Yes □ No – Do your gums bleed when brushing/flossing?
□ Yes □ No – Do you have any sores or lumps in or near your mouth?
□ Yes □ No – Do you feel pain in any of your teeth?
□ Yes □ No – Have you had any head, neck or jaw injuries?
□ Yes □ No – Do you wear dentures/partials? How long? _____
□ Yes □ No – Have you had prolonged bleeding with extractions in the past?
□ Yes □ No – Are your teeth sensitive to hot/cold, sweet/sour, liquids/foods?

□ Yes □ No – Have you had braces?
□ Yes □ No – Do you bite your lips or cheeks?
□ Yes □ No – Do you have frequent headaches?
□ Yes □ No – Do you clench or grind your teeth?
□ Yes □ No – Do you like your smile?

Have you ever experienced any of the following in your jaw?

Clicking/Popping? □ Yes □ No **Pain?** □ Yes □ No **Difficulty opening/closing?** □ Yes □ No

AUTHORIZATION AND RELEASE

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I experience a change in my health, I will inform the dentist(s) of McHenry Dental Specialists at my next appointment without fail. I hereby authorize McHenry Dental Specialists to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant my permission to McHenry Dental Specialists to release my dental/medical histories and any other information about my dental treatment to third party payors &/or other health professionals. I also authorize payment directly to McHenry Dental Specialists from my insurance company or companies for my group insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of my dental treatment regardless of insurance coverage &/or estimates received. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian: _____ Date: _____

Relationship to patient: _____