MEDICAL CONSENT FORM

Medical History Form

Patient Name:_____

D.O.B:_____ Place of Birth: _____

Address: _____Postal Code: _____

Home Phone #:_____Cell Phone#:_____ Height: _____ Weight: _____

Email: _____ FT Student Y/N, School: _____

Emergency Contact: _____ Phone #: _____

Physician Name:_____ Phone #: _____

Medical History

Date of last medical check-up: _____

Have you been treated for any conditions currently or in the past year? ___Yes ___No

Have you ever been hospitalized? ___Yes ___No

If yes, for what?_____

Have you ever had any surgeries? ___Yes ___No

If yes, for what and when were they? _____

_____

Current Medications: _____

_____

Please list any allergies (medication, environmental, food, etc.):_____

_____

Symptoms of allergic reaction:_____

Have you ever been told you require pre-medication prior to dental treatment? ___Yes ___No

Reason for required pre-medication? _____

Do you have a family history of: ____Heart Disease ____Cancer ____Diabetes?

Do you get frequent: ____Headaches ____Earaches ____Ear/nose/throat Infection?

Do you get frequent indigestion or nausea? ___Yes ___No

Do you heal slowly? ___Yes ___No

Do you have a history of excessive bleeding or bruising? ___Yes ___No

Do your ankles, hands, or feet swell? ___Yes ___No

MEDICAL CONSENT FORM

Do you experience any numbness or paralysis in any part of your body? ___Yes ___No

Have you had a sudden change in your weight, appetite, or energy level? ___Yes ___No

Do you have any difficulties swallowing or hearing? ___Yes ___No

Any history of chest pain or shortness of breath? ___Yes ___No

Do you have a history of asthma? ___Yes ___No

Are you pregnant or suspect you may be? ___Yes ___No Due Date:_____

Are you currently breastfeeding? ___Yes ___No

Are you on birth control pill? ___Yes ___No

Are you aware of your bone mineral density? ___Yes ___No

Do you use tobacco products? ___Yes ___No If yes, how many per day? _____

Do you have, or have you had, any of the following conditions: (Please check all that apply)

___HIV/AIDS	___Emphysema	___Herpes	__Radiation Treatment
___Anemia	___Epilepsy/Seizures	___High/Low Blood Pressure	___Chemotherapy
___Angina Pectoris	___Fainting/Dizzy spells	___Hodgkins Disease	___Sickle Cell Disease
___Arthritis/Rheumatism	___Glandular Disorders	___Hyper/Hypo Glycemia	____Scarlet or Rheumatic Fever
___Artificial Joints	___Head/Neck Injuries	___Inflammatory Bowel Disease	___Sinus Trouble
___Blood Disorders	__Heart Disease/Attack	___Jaundice	___Intestine or Ulcer Problems
___Bronchitis	___Heart Murmur	___Kidney Disease	___Stroke
___Cancer	___Heart Pacemaker	___Liver Disease	___Thyroid disease
___Circulation Problems	___Heart Surgery	___Lung Disease	___Tuberculosis
___Congenital Heart Defects	___Heart Rhythm Disorder	___Lupus	___Sexually transmitted infection
___Cortisone/Steroid	___Hepatitis A	___Mental/Nervous Disorder	___Treacher-Collins Syndrome
___Crohn's Disease	___Hepatitis B	___Organ Transplant	
___Diabetes	___Hepatitis C	___Medical Implant	

Do you suffer from dental fear? ___Yes ___No

Patient Certification and Approval

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient/Guardian Signature: _____**Date:** _____