

## MEDICAL HISTORY

### ALLERGIES:

Aspirin                     Nitrous Oxide  
 Clindamycin            Penicillin/Amox.  
 Codeine                    Percodan  
 Demerol                  Sulfa  
 Erythromycin          Valium  
 Ibuprofen               Tetracycline  
 Local Anes.

### List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Women only: are you pregnant? \_\_\_\_\_

Are you taking birth control pills? \_\_\_\_\_

### Additional allergies to any other medication or substance:

\_\_\_\_\_

### CHECK ANY SYMPTOMS OR CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD:

<input type="checkbox"/> Aids/HIV Positive	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/Seizure History	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Earache	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Painful Jaw Joint
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Chemo, X-Ray or Cobalt Trt	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sinus Problems
___ <i>currently</i> ___ <i>previously</i>	<input type="checkbox"/> Hepatitis Type _____	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Herpes	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Jaundice/Liver Disease	

General Physician's Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## DENTAL HISTORY

Date of last dental visit: \_\_\_\_\_ Date of last cleaning: \_\_\_\_\_ X-rays taken: Y or N

3<sup>rd</sup> molars (wisdom teeth) extracted: Y or N Date of extraction: \_\_\_\_\_

Are you having discomfort at this time? \_\_\_\_\_

The undersigned authorizes Dr. Whitener to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Whitener to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Whitener to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Whitener may choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

SIGNED \_\_\_\_\_