# MEDICAL HISTORY and CONSENT

**Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.**

**Allergies**

| | | |
|---|---|---|
| Acrylics | Y | N |
| Anaphylaxis | Y | N |
| Latex | Y | N |
| Local Anesthetics | Y | N |
| Penicillin | Y | N |
| Metal | Y | N |
| Sulfa | Y | N |
| Other | Y | N |

List other known allergies:

_____

_____

_____

_____

_____

**Cardiovascular**

| | | |
|---|---|---|
| Artificial Heart Valve | Y | N |
| Coronary Artery Disease | Y | N |
| Chest Pain or Angina | Y | N |
| Congestive Heart Failure | Y | N |
| Heart Attack | Y | N |
| Heart Murmur | Y | N |
| High Blood Pressure | Y | N |
| High Cholesterol | Y | N |
| Irregular Heart Beat | Y | N |
| Low Blood Pressure | Y | N |
| Mitral Valve Prolapse | Y | N |
| Pacemaker | Y | N |
| Tachycardia | Y | N |

**Endocrine**

| | | |
|---|---|---|
| Diabetes | Y | N |
| Gout | Y | N |
| Hormonal Change | Y | N |
| Thyroid problems | Y | N |

**Eyes, Ears, Nose and Throat**

| | | |
|---|---|---|
| Change in Hearing | Y | N |
| Change in Vision | Y | N |
| Dysphagia | Y | N |
| Ear Pain | Y | N |
| Glaucoma | Y | N |
| Hay Fever | Y | N |
| Nasal Obstruction | Y | N |
| Nose Bleeding | Y | N |
| Sinus Problems | Y | N |
| Tonsillectomy | Y | N |
| Tinnitus | Y | N |

**Gastrointestinal**

| | | |
|---|---|---|
| Acid Reflux | Y | N |
| GERD | Y | N |
| Soft or Special Diet | Y | N |
| Ulcers | Y | N |

**Genitourinary**

| | | |
|---|---|---|
| Frequent Urination | Y | N |
| Kidney disease | Y | N |
| Nocturia | Y | N |

**General**

Current weight: _____lbs

Height: _____ ft _____in

| | | |
|---|---|---|
| Cancer | Y | N |
| Fatigue/Tired | Y | N |
| General Weakness | Y | N |
| Headaches | Y | N |
| HIV/AIDS | Y | N |
| Knee/hip replacement | Y | N |
| Liver problems | Y | N |
| Recent Trauma or Injury | Y | N |
| Rheumatic Fever | Y | N |
| Radiation Treatment | Y | N |
| Weight Change | Y | N |

**Hematological**

| | | |
|---|---|---|
| Bleeding problems | Y | N |
| Hepatitis | Y | N |

**Oral**

| | | |
|---|---|---|
| Bleeding gums | Y | N |
| Dry mouth | Y | N |
| Jaw problems (TMJ)? | Y | N |
| Clicking? | Y | N |
| Pain? | Y | N |
| Difficulty swallowing? | Y | N |
| Difficulty chewing? | Y | N |
| Orthodontics/Invisalign | Y | N |
| Periodontal Disease | Y | N |
| Teeth clenching | Y | N |
| Teeth grinding | Y | N |
| Tooth pain | Y | N |
| Wisdom teeth extraction | Y | N |
| Do you wear removable teeth? | Y | N |
| Do you take or need antibiotics before dental procedures? | Y | N |

**Musculoskeletal**

| | | |
|---|---|---|
| Back Pain | Y | N |
| Fibromyalgia | Y | N |
| Joint Pain | Y | N |

**Neurological**

| | | |
|---|---|---|
| Alzheimer's Disease | Y | N |
| Dizziness | Y | N |
| Fainting | Y | N |
| Memory Loss | Y | N |
| Multiple Sclerosis (MS) | Y | N |
| Muscle Weakness | Y | N |
| Seizures | Y | N |
| Stroke | Y | N |
| Tingling/Numbness | Y | N |
| Trigeminal Neuralgia | Y | N |
| Tremor | Y | N |

**Psychiatric**

| | | |
|---|---|---|
| ADD/ADHD | Y | N |
| Anxiety | Y | N |
| Chemical Dependency | Y | N |
| Depression | Y | N |
| Eating disorders | Y | N |
| Excessive Stress | Y | N |
| Memory problems | Y | N |

**Respiratory**

| | | |
|---|---|---|
| Asthma | Y | N |
| Bronchitis | Y | N |
| Breathing problems | Y | N |
| Chest Pressure | Y | N |
| Congestion | Y | N |
| Dyspnea(shortness of breath) | Y | N |
| Emphysema | Y | N |
| Orthopnea | Y | N |
| Pneumonia | Y | N |
| Pulmonary Embolism | Y | N |
| Tuberculosis | Y | N |

**Sleep**

| | | |
|---|---|---|
| Daytime Sleepiness | Y | N |
| Morning headaches | Y | N |
| Obstructive Sleep Apnea | Y | N |
| Do you use a CPAP? | Y | N |

How often? _____

| | | |
|---|---|---|
| Has anyone told you that you snore? | Y | N |

**Social History**

Do you smoke? N Y ___ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages? Y N

_____Drinks per day/week/month

Do you use recreational drugs? Y N

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