Abundant DENTAL CARE

Patient's Name:

MEDICAL HISTORY FORM

Please check any of the following problems/conditions that apply to you:

☐ AIDS
☐ Allergies (seasonal)
☐ Anemia
☐ Angina (chest pain)
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bruise easily
☐ Cancer
☐ Chemotherapy
☐ Cortisone Medication
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart Condition
☐ Hepatitis A, B or C
☐ High Blood Pressure
☐ HIV Positive
☐ HPV
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervousness/Depression
☐ Pacemaker
☐ Pregnant (currently)
☐ Radiation (head/neck)
☐ Respiratory problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Seizures
☐ Sinus problems
☐ Sleep Apnea
☐ Stomach problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Other ____________

Are you allergic or have you reacted adversely to any of the following medications?

☐ Aspirin
☐ Darvon
☐ Nitrous Oxide
☐ Percodan
☐ Latex
☐ Local Anesthetic
☐ Tetracycline
☐ Codeine
☐ Erythromycin
☐ Valium
☐ Penicillin
☐ Sulfa
☐ Other ____________

Have you ever taken any of the following medications?

☐ Actonel
☐ Aredia
☐ Fosamax
☐ Reclast
☐ Zometa
☐ Boniva
☐ Herbal Supplements
☐ Other ____________

Are you under a physician's care? If yes, for what reason?

____

____

____

Please list current medications:

____

____

____

Name of Physician: ____________

Phone: ____________

Do you currently smoke or use tobacco? Y or N

If so, for how long? ____________

Sleep Questionnaire

0 - *No chance of dozing*
1 - *Slight chance of dozing*
2 - *Moderate chance of dozing*
3 - *High chance of dozing*

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (e.g., a theater or a meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

Total ________

Consent: *I, the undersigned, hereby authorize Abundant Dental Care and its doctors and/or employees to take X-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I also authorize any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.*

Patient's Printed Name

Signature *(Patient, legal guardian or authorized agent of patient)*

Date

Provider's Signature

Date