DENTAL CLINIC ** MEDICAL HEALTH HISTORY

Client's Name: ____ Date of Birth: ________________________

List any known **ALLERGIES** (including allergies to medications and latex). If none, put NONE

________________________________ ___________________________ ______________________________
________________________________ ___________________________ ______________________________

List all **MEDICATION(S)** being taken at the present time and the reason they are taken: If none, put NONE.

________________________________ ___________________________ ______________________________
________________________________ ___________________________ ______________________________
________________________________ ___________________________ ______________________________
________________________________ ___________________________ ______________________________

Height ________ Weight ________ Does the client smoke? ______ How much? ______ How many years? ______

Adult Dental Clinic Clients: Do you drink? ______ How many drinks per week? ______

PLEASE INDICATE ANSWERS BELOW WITH AN "X" Is there (**the client**) a **history** of:	**UNCERTAIN**	**NO**	**YES**
Any past complications with tooth extractions:	☐	☐	☐
Any excessive bleeding following a minor cut:	☐	☐	☐
Any immune system problems (such as lupus, rheumatoid arthritis, HIV/AIDS)	☐	☐	☐
Any radiation treatment or chemotherapy for cancer or other disease:	☐	☐	☐
Heart murmur or Congenital Heart Defects:	☐	☐	☐
Rheumatic fever:	☐	☐	☐
Diabetes:	☐	☐	☐
Lung disease, Bronchitis, Shortness of Breath or Asthma:	☐	☐	☐
Heart disease or chest pain:	☐	☐	☐
Kidney or Liver Problems:	☐	☐	☐
Cancer:	☐	☐	☐
Tuberculosis (TB):	☐	☐	☐
Epilepsy, Convulsions, or seizure disorder:	☐	☐	☐
Hemophilia:	☐	☐	☐
Any Surgeries:	☐	☐	☐
Any Hospitalizations:	☐	☐	☐

Please list any handicaps, disabilities, or other medical concerns not listed above: ____

Please list any serious medical problems: ____

Is this client receiving any other health care services at this time? If so please explain: ______________________________

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For Females ONLY:. Please note that antibiotics may be prescribed and can alter the effectiveness of oral birth control medications. Consult with your primary physician regarding oral contraceptives and antibiotic usage.

Is there a possibility of pregnancy? (Please Circle) Yes No

If yes, we must have written approval for dental treatment from the physician monitoring the pregnancy.

Permission of Parent or Legal Guardian, if applicable, is necessary for dental treatment of a minor. If you are unable to accompany the child to the appointment, a proxy form authorizing the person with the child to sign the Consent for Treatment must be on file with the Health Department. This must be done in advance of the appointment.

NOTE: **Step Parents would be a Proxy so the biological parent must complete the Blue Proxy form before a step-parent can bring the child and give consent for treatment.**

CONSENT FOR TREATMENT Please read the following carefully.

I hereby authorize the dentist or designated staff to take x-rays or photographs and to use other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics and other medication as necessary. I fully understand that using some anesthetic agents embodies some risk. I understand that I can ask for a complete recital of any possible complications.

I understand the health history questions above and have answered them as accurately as possible.

PARENT/GUARDIAN/CLIENT SIGNATURE_______________________________________**DATE**:___________________

Relationship to Child if the Client is under the age of 18:___________________

Dental Clinician Review Area:

Date form reviewed:__________________________ Initials of Clinician:__________________

Date form reviewed:__________________________ Initials of Clinician:__________________

Date form reviewed:__________________________ Initials of Clinician:__________________

Date form reviewed:__________________________ Initials of Clinician:__________________

Date form reviewed:__________________________ Initials of Clinician:__________________

Date form reviewed:__________________________ Initials of Clinician:__________________

Date form reviewed:__________________________ Initials of Clinician:__________________

This form should be reviewed by the Parent/Legal Guardian and updated every year or sooner if any changes occur:

Date form reviewed and or updated:__________________________ Initials of Parent or legal guardian:______________________

Date form reviewed and or updated:__________________________ Initials of Parent or legal guardian:______________________

Date form reviewed and or updated:__________________________ Initials of Parent or legal guardian:______________________

Date form reviewed and or updated:__________________________ Initials of Parent or legal guardian:______________________

Date form reviewed and or updated:__________________________ Initials of Parent or legal guardian:_____________________