BRICKYARD
DENTAL CLINIC

Medical History

(this information will remain confidential)

Medical Alert ____________

Date: ____________

1. Are you currently in the care of a physician for any medical condition(s)? Yes ☐ No ☐ If so, explain: ____________

2. Have you ever been hospitalized and/or had major surgery? Yes ☐ No ☐ Explain: ____________

3. Are you taking any drugs or medication at this time? (includes cannabis) Yes ☐ No ☐

A) Drug ____________ Reason ____________
B) Drug ____________ Reason ____________
C) Drug ____________ Reason ____________
D) Drug ____________ Reason ____________
E) Drug ____________ Reason ____________

4. Have you ever had any adverse reaction to any of the following: Antibiotic: Penicillin ☐ Sulfonamide ☐ Other ☐

Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Darvon ☐ Local Anesthetic ☐ NONE ☐

5. Do you suffer from any allergies (hay fever. latex etc.)? Specify ____________ Yes ☐ No ☐

6. Do you bruise easily or have prolonged bleeding? Specify ____________ Yes ☐ No ☐

7. Do you smoke? How much per day ____________

8. Have you ever fainted. had shortness of breath or chest pains? Specify ____________

9. Women: Are you pregnant? Yes ☐ No ☐ Reached menopause? Yes ☐ No ☐

10. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. NONE ☐

☐ AIDS
☐ Anemia
☐ Angina Pectoris
☐ Anorexia nervosa
☐ Artificial Heart valve
☐ Arthritis/rheumatism
☐ Artificial joints (hips, knees)
☐ Asthma
☐ Blood disorders
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Circulation problems
☐ Congenital heart lesions

☐ Cortisone/steroid
☐ Diabetes
☐ Drug/alcohol dependence
☐ Emphysema
☐ Epilepsy
☐ Glandular disorders
☐ Glaucoma
☐ Head/Neck injuries
☐ Heart disease/attack
☐ Heart murmur
☐ Heart pacemaker/surgery
☐ Heart rhythm disorder
☐ Hepatitis A/B/C
☐ Herpes

☐ High/Low Blood pressure
☐ H.I.V. Positive
☐ Hodgkin disease
☐ Hyper (Hypo) Glycemia
☐ Hypertension
☐ Jaundice
☐ Kidney disease
☐ Liver disease
☐ Leukemia
☐ Lung disease
☐ Mental/nervous disorder
☐ Mitral valve collapse
☐ Organ transplant/implant
☐ Psychiactric disorders

☐ Radiation/Chemotherapy
☐ Rheumatic/Scarlet fever
☐ Sickle Cell disease
☐ Sinus trouble
☐ Stomach/intestinal problems
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal disease
☐ Other ____________
☐ Other ____________
☐ Other ____________
☐ Other ____________

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

____________ Signature ☐ Patient ☐ Parent./Guardian

____________ Print Name

____________ Date