KENNEWICK DENTAL PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____
Physician Name: _____ Phone: _____
Date of last physical exam: _____ Are you under the care of a physician now? ☐ Yes ☐ No
If **yes**, please explain: _____
Have you ever been hospitalized, and if so for what? _____

CIRCLE any of the following conditions you have or have had in the past:

Abnormal/Excessive Bleeding	Cancer	Heart Defects	Psychiatric Care
Acid Reflux/Persistent Heartburn	Cardiovascular Disease	Heart Murmur	Radiation Therapy
AIDS or HIV Infection	Chemotherapy	Heart Surgery	Rheumatoid Arthritis
Allergies/Hay Fever	Chronic Pain	Hemophilia	Rheumatic Fever
Alzheimer's Disease	Congestive Heart Failure	Hepatitis	Scarlet Fever
Anemia	COPD	High Blood Pressure	Sickle Cell Disease
Angina	Dementia	HIV/AIDS	Sinus Trouble
Anxiety	Depression	Jaundice	Stroke
Arthritis	Diabetes	Kidney Problems	Swollen Glands in Neck
Artificial Heart Valve	Drug Addiction	Leukemia	Thyroid Problems
Artificial Joints	Emphysema	Liver Disease	TMJ Disorder
Asthma	Epilepsy/Seizures	Low Blood Pressure	Tobacco Use
Autoimmune Disease	Fever Blisters	Mitral Valve Prolapse	Venereal Disease
Blood Disease	GERD/Reflux	Nervousness	
Blood Thinners	Glaucoma	Osteoporosis	
Breathing Problems/Respiratory	Hearing Difficulties	Pacemaker	
Disease	Heart Attack	Paget's Disease	

CIRCLE any of the following medications you are allergic to or that have caused reactions:

Acetaminophen/Tylenol	Codeine	Keflex	Oxycodone
Acrylic	Corticosteroids	Latex	Penicillin
Aspirin	Epinephrine	Local Anesthetic	Percodan
Augmentin	Erythromycin	Macrobid	Sulfa
Cephalexin	Hydrocodone	Mint	Valium
Cephalosporins	Ibuprofen/Motrin/Advil	Nitrous Oxide	Z-Pak
Clindamycin	Iodine	NSAIDs	NO KNOWN DRUG ALLERGY

List any other medications that you are knowingly allergic to or have a bad reaction to: _____

List ALL medications you are currently taking: _____

Are you taking any medications for **Osteoporosis**? ☐ Yes ☐ No
Are you currently **Pregnant**, trying to get pregnant, or nursing? (PLEASE CIRCLE) ☐ Yes ☐ No
Are you currently taking Birth Control Pills? ☐ Yes ☐ No
Is there any other medical information not included above? ☐ Yes ☐ No
If yes, please explain: _____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Madder, Barney, DMD, PLLC and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Madder, Barney, DMD, PLLC and/or their trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

Signature of Patient/Parent or Guardian _____ Reviewed By _____ Date _____