

MEDICAL History Update

YOUR NAME: _____ Today's Date: _____

Physician's Name: _____ Phone #: _____ When was your last visit to your physician? _____

When was your last complete physical? _____

Please tell us if you have had any of the following by checking the appropriate box:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Any Artificial Replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Disease | Artificial Knee, Hip, Joint, | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Sickle Cell Anemia | Pins, Plate | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia / Blood Problems | <input type="checkbox"/> Rheumatism / Arthritis | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Heart Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Ulcer / Colitis |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Attack _____ year | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Angina/ Chest Pain | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Pregnant _____ months |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancers, Tumors, Growths | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Immunosuppressive | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Congestive Heart Failure | Disorders / ARC | | |

Please list any ALLERGIES to Drugs, Medications or Anesthetics:

Please list any other MEDICAL CONDITIONS not mentioned above:

Please list all DRUGS/MEDICATIONS that you currently take:

Patient Signature

Date

AUTHORIZATION for TREATMENT: This is to certify that I, the undersigned Patient or Guardian, consent to all dental procedures agreed to between myself and John V. Sullivant, DDS, PA, including the use of local, inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. John V. Sullivant, DDS, PA, at his discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

Patient's (Guardian's) Signature

Date