MEDICAL HISTORY

{The following answers are for our records only and will be considered confidential}

Patient Name: _____Date of Birth: _____

Your Physician's Name: _____

Have you ever had any of the following?
(Check boxes that apply):

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bone Infection
- ☐ Diabetes
- ☐ Emotional Disturbances
- ☐ Epilepsy
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV positive test
- ☐ Liver/Kidney Disease
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ **Rheumatic Fever**
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors/Cancer
- ☐ Venereal Disease

Y ☐ N ☐ Are you currently under medical treatment? If yes, please explain_____

_____

Y ☐ N ☐ Have you been hospitalized in the past five years? If yes, please explain_____

_____

Y ☐ N ☐ Have you had any surgeries? _____

Y ☐ N ☐ Heart surgery? _____

Y ☐ N ☐ Have you had any joint replacements, received implants or donors? _____

Y ☐ N ☐ Have you had any reactions to any medications? If yes, please explain_____

_____

Y ☐ N ☐ Are you currently taking any medications or drugs? If yes, please explain_____

_____

Y ☐ N ☐ Are you sensitive to metals, latex, or other materials? If yes, please explain_____

_____

Y ☐ N ☐ Do you smoke or use smokeless tobacco? How much per day? _____

Y ☐ N ☐ Are you pregnant? Due date_____

DENTAL HISTORY

Last dental visit: Month_____Year_____Reason_____

Previous Dentist: _____City, State: _____

Y ☐ N ☐ Have you had local anesthetic? Y ☐ N ☐ Do you have any sores, growths or spots in your mouth?

Y ☐ N ☐ Do you have a specific dental problem? _____

What, if anything, would you like to change about your smile? _____

_____

Would you like to have a whiter smile? _____

Have you had any prior dental experiences that we should be aware of? _____

_____

I hereby give my consent for dental procedures for myself or for _____. I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Greg Zlock and his supervised staff. I certify that the above answers are accurate and complete to the best of my knowledge.

Signature_____ **Date**_____