MEDICAL HEALTH HISTORY

Do you have or have you had any of the following (Please check any that apply)

YES NO

- ❑ ❑ Cancer or tumor
- ❑ ❑ Heart disease
- ❑ ❑ Heart attack, heart defects
- ❑ ❑ Heart murmurs?
- ❑ ❑ Rheumatic fever or rheumatic heart disease
- ❑ ❑ Pacemaker
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Hight cholesterol
- ❑ ❑ Asthma
- ❑ ❑ Tuberculosis or other lung problems
- ❑ ❑ Hayfever or sinus trouble
- ❑ ❑ Allergies or hives
- ❑ ❑ Diabetes
- ❑ ❑ Arthritis
- ❑ ❑ VD (syphilis or gonorrhea)
- ❑ ❑ AIDS or HIV positive
- ❑ ❑ Herpes
- ❑ ❑ Cold sores
- ❑ ❑ Hepatitis or other liver disease
- ❑ ❑ Migraine headaches or frequent headaches
- ❑ ❑ Anemia or blood disorders
- ❑ ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ ❑ Blood transfusions
- ❑ ❑ Thyroid Disease
- ❑ ❑ Kidney, bladder disease
- ❑ ❑ Radiation, Chemotherapy treatments
- ❑ ❑ Stomach problems, ulcers
- ❑ ❑ Artificial joint or valve
- ❑ ❑ Epilepsy, seizures, or fainting spells
- ❑ ❑ Psychiatric care
- ❑ ❑ Do you smoke or use chewing tobacco

Premedication required by physician? Yes❑ No❑

Are you allergic to, or have you reacted adversely to any of the following?

YES NO

- ❑ ❑ Latex material
- ❑ ❑ Penicillin, amoxicilin
- ❑ ❑ Local anesthetics ("Novocain")
- ❑ ❑ Codeine or other narcotics
- ❑ ❑ Sulfa drugs
- ❑ ❑ Barbiturates, sedatives, or sleeping pills
- ❑ ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

YES NO

- ❑ ❑ Aspirin
- ❑ ❑ Anticoagulants (blood thinners)
- ❑ ❑ Antibiotics or sulfa drugs
- ❑ ❑ High blood pressure medicine
- ❑ ❑ Antidepressants or tranquilizers
- ❑ ❑ Insulin, Orinase, or other diabetes drug
- ❑ ❑ Nitroglycerin
- ❑ ❑ Cortisone or other steroids
- ❑ ❑ Osteoporosis (bone density) medicine
- ❑ ❑ List Medications you are currently taking: _____

_____

_____

Women:	**Yes**	**No**
Are you or could you be pregnant?	❑	❑
Taking hormones or contraceptives?	❑	❑
Are you nursing?	❑	❑

Name of your physician:_____

Do you have any disease, condition, or problem not listed above? _____

_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize **Dr. Bustillo/Featherston** to release my information including diagnosis and the records to any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Consent:

I consent to the dental x-rays, diagnostic procedures and treatment by the dentist necessary for proper dental care. By signing this I authorize communications for my health information via unsecured email & I understand that I have the right to revoke the authorization at any time after written notice from me

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative ***Date***

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative ***Date***