Time 11:39 AM | Drs. Kurzman And Lacy, LLC | Date 10/6/2016

Medical History - Version 2/2016

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following.

If additional space is needed for any of your responses, please use the back of this form.

Are you under a physician's care for any ongoing medical condition(s)?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications or supplements?	○ Yes ○ No	If yes
Are there any medications that you have recently stopped taking?	○ Yes ○ No	If yes
Do you smoke or use other tobacco products?	○ Yes ○ No	If yes
Do you drink alcohol?	○ Yes ○ No	If yes
Are you required to take an antibiotic Pre-Med prior to dental treatments?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Anemia	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Fainting Spells/Dizzines	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Cancer	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Cold Sores/Fever Blister	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	AIDS/HIV Positive	○ Yes ○ No	Dementia	○ Yes ○ No
Blood Disease	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Hemophilia	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Renal Dialysis	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Cardiac Problems	○ Yes ○ No	Liver Disease	○ Yes ○ No

Have you ever had any other illness/condition(s) not listed above?	○ Yes ○ No	If yes
In case of an emergency, is there anyone you'd like us to contact? If yes, list their name and number	○ Yes ○ No	If yes
Is there a friend or family member with whom we can share your dental information with?	○ Yes ○ No	If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____