Medical Health History

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

(Check if yes)

Heart Problems _____ ☐
Chest Pains _____ ☐
Shortness of Breath _____ ☐
High or Low Blood Pressure _____ ☐
Heart Murmur _____ ☐
Heart Valve Problems _____ ☐
Rheumatic fever _____ ☐
Pacemaker _____ ☐
Artificial Heart Valve _____ ☐
Recent Heart surgery _____ ☐
Blood disease _____ ☐
Blood transfusion _____ ☐
Allergy Problems _____ ☐
Hay fever _____ ☐
Sinus Problems _____ ☐
Asthma _____ ☐
Intestinal Problems _____ ☐
Kidney or Bladder disease _____ ☐
Hepatitis or Liver disease _____ ☐
Arthritis _____ ☐
Joint Replacement _____ ☐
Epilepsy, Seizures, or fainting spells _ ☐
Stroke _____ ☐
Frequent or Severe Headaches _____ ☐
Thyroid Problems _____ ☐
Persistent cough or swollen glands ___ ☐
Cancer/ Tumor _____
Premedications required by physician ☐

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

Local anesthetics ☐
Penicillin or other antibiotics ☐
Sulfa drugs ☐
Barbiturates, sedatives, or sleeping pills ☐
Aspirin, Acetaminophen, or Ibuprofen ☐
Codeine, Demerol, or other narcotics ☐
Reaction to metals ☐
Latex or Latex products ☐
Other: _____

Diabetes _____ ☐
Tuberculosis _____ ☐
Other Respiratory Disease _____ ☐
Herpes or other STD _____ ☐
HIV-positive or AIDS _____ ☐
Glaucoma _____ ☐
History of Alcohol or Drug Addiction ☐
Smoke _____ □
Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: _____
_____
_____
Surgery_____ □
Date and Reason _____
_____

During the past 12 months, have you taken any of the following medications?

Antibiotics or Sulfa drugs ☐
Anticoagulants (e.g., Coumadin) ☐
High blood pressure medication ☐
Tranquilizers ☐
Insulin, Orinase, or similar drug ☐
Aspirin ☐
Nitroglycerin ☐
Cortisone ☐
Natural remedies ☐
Nonprescription drugs/supplements ☐
Other _____
_____

Women

Are you taking oral contraceptive? ☐
or other hormone therapy? ☐
Are you pregnant? ☐
If so, expected date of delivery:
Are you nursing? ☐

Notes: _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by Dr.G.Robert Marye and his staff. I authorize Dr. Marye to request any medical or dental information that is deemed necessary for my care and to file my insurance for me. As a courtesy, we file your insurance for you. However, Dr. Marye is an out of network provider. I understand and accept that I am financially responsible for the entire fee charged regardless of any third party involvement. I release benefits from my dental insurance to be paid directly to Dr. Marye.

Signature _____ Date: _____ Staff Initials: ____