



## Medical History

Please take a moment to answer the following important health related questions.  
Your answers will help us to provide you with the best in patient care.

Your Primary Physician's Name & Phone Number: \_\_\_\_\_

- | <u>Conditions</u>            | <u>Conditions</u>        | <u>Conditions</u>           |
|------------------------------|--------------------------|-----------------------------|
| Y N Heart Murmur             | Y N Liver Disease        | Y N Artificial Heart Valve  |
| Y N Venereal Disease/STD's   | Y N Kidney Problems      | Y N Artificial Bones/Joints |
| Y N Ulcers                   | Y N HIV+/AIDS            | Y N Arthritis               |
| Y N Tuberculosis             | Y N High Blood Pressure  | Y N Angina Pectoris         |
| Y N Thyroid Problems         | Y N Hepatitis B          | Y N Anemia                  |
| Y N Stroke                   | Y N Hepatitis A          | Y N Allergies               |
| Y N Sinus Problems           | Y N Hepatitis C          | Y N Sickle Cell Anemia      |
| Y N Hemophilia               | Y N Abnormal Bleeding    | Y N Cancer-Chemotherapy     |
| Y N Heart Attack/Date: _____ | Y N Reflux               | Y N Blood Transfusion       |
| Y N Shingles                 | Y N Hay Fever            | Y N Asthma                  |
| Y N Seizures                 | Y N Glaucoma             | Y N Fainting Spells         |
| Y N Rheumatic Fever          | Y N Frequent Headaches   | Y N Drug Abuse              |
| Y N Radiation Therapy        | Y N Fever Blisters       | Y N Low Blood Pressure      |
| Y N Colitis                  | Y N Psychiatric Problems | Y N Diabetes                |
| Y N Pace Maker               | Y N Emphysema            | Y N Congenital Heart Defect |
| Y N Mitral Valve Prolapse    | Y N Difficulty Breathing | Y N Pre-Med                 |

Do you smoke or use tobacco: YES NO

Have you ever used the drug "Fen-Phen"? YES NO

\*Any other condition not listed, please describe here: \_\_\_\_\_

### Allergies:

- |                        |                  |
|------------------------|------------------|
| Y N Aspirin            | Y N Jewelry      |
| Y N Codeine            | Y N Latex        |
| Y N Dental Anesthetics | Y N Metals       |
| Y N Erythromycin       | Y N Penicillin   |
| Y N Sulfa              | Y N Tetracycline |

Other: \_\_\_\_\_

### Females Only:

- Y N Are you taking birth control pills?  
 Y N Are you nursing?  
 Y N Are you pregnant?  
 # of weeks \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

I request and authorize Dr. Roth and/or his associate and assistants to examine, clean and provide my/the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. I understand that this office only uses composite (tooth-colored) filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_