HARDER DENTAL COPORTATION
CONFIDENTIAL MEDICAL HISTORY
TO BE KEPT CONFIDENTIAL

Although dental clinicians primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems and medications you may or have had/used or are presently existing, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Patient Name:_____ Age:_____
Name of Physician & their specialty:_____ Phone:_____
Most recent physical exam:_____ Purpose:_____
Are you under the care of a physician now? □ Yes □ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain:_____
Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain:_____
Have you ever taken/do you take bisphosphonates, ie:Fosmax® □ Yes □ No If yes, please explain:_____
Are you on a special diet? □ Yes □ No If yes, please explain:_____
Do you smoke or use tobacco? □ Yes □ No If yes, type:_____ Usage:_____
Do you wear a cardiac pace maker, or have had heart surgery? □ Yes □ No If yes, when:_____ Date placed:_____
Have you ever been premedicated with antibiotics for dental treatment? □ Yes □ No If yes, please explain:_____
Are you using any recreational drugs (marijuana, cocaine, etc.)? □ Yes □ No If yes, please explain:_____

Are you allergic or sensitive to any drugs or materials? □ Yes □ No □ Penicillin □ Tetracycline □ Sulfa Drugs □ Erythomycin □ Codeine □ Aspirin, Ibuprofen, acetaminophen □ Local Anesthetics □ Latex □ Fluoride □ Acrylic □ Metals □Other_____

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

Y N AIDS/HIV Positive	**Y N** Convulsions	**Y N** Hemophilia	**Y N** Radiation Treatment
Y N Alzheimer's Disease	**Y N** Cortisone Treatment	**Y N** Hepatitis A	**Y N** Recent Weight Loss
Y N Anaphylaxis	**Y N** Diabetes	**Y N** Hepatitis B or C	**Y N** Respiratory Disease
Y N Anemia	**Y N** Difficulty Swallowing	**Y N** Herpes	**Y N** Rheumatic Fever
Y N Angina	**Y N** Digestive Disorders	**Y N** High Cholesterol	**Y N** Rheumatism
Y N Any Lumps or Swelling in Mouth	**Y N** Drug/Alcohol Addiction	**Y N** High Blood Pressure	**Y N** Scarlet Fever
Y N Antidepressant Medications	**Y N** Easily Winded	**Y N** Hives or Rash	**Y N** Shingles
Y N Arthritis/ Gout	**Y N** Emotional Problems	**Y N** Hormone Deficiency	**Y N** Sickle Cell Disease
Y N Artificial Heart Valve	**Y N** Emphysema	**Y N** Hypoglycemia	**Y N** Sinus Trouble
Y N Artificial Joint/ Replacement	**Y N** Epilepsy/ Seizures	**Y N** Implant(s)	**Y N** Sleep Apnea
Y N Asthma	**Y N** Excessive Bleeding	**Y N** Irregular Heart Beat	**Y N** Snoring
Y N Blood Disease	**Y N** Excessive Thirst	**Y N** Jaundice	**Y N** Spina Bifida
Y N Blood Transfusion	**Y N** Fainting Spells/ Dizziness	**Y N** Kidney Problems	**Y N** Stomach/ Intestinal Disease
Y N Breathing Problems	**Y N** Frequent Cough	**Y N** Liver Disease	**Y N** Stroke
Y N Bruise Easily	**Y N** Frequent Diarrhea	**Y N** Low Blood Pressure	**Y N** Swelling of Limbs
Y N Cancer	**Y N** Genital Herpes	**Y N** Lung Disease	**Y N** Thyroid Disease
Y N Cerebal Palsy	**Y N** Glaucoma	**Y N** Mental Disorders	**Y N** TMJ Disorders
Y N Chemotherapy	**Y N** Hay Fever	**Y N** Mitral Valve Prolapse	**Y N** Tonsillitis
Y N Chest Pains	**Y N** Head/ Neck Injury	**Y N** Nervous Disorders	**Y N** Tumors or Growths
Y N Chicken Pox	**Y N** Headaches	**Y N** Osteoporosis	**Y N** Ulcers
Y N Cold Sores/ Fever Blisters	**Y N** Heart Attack/ Failure	**Y N** Pain in Jaw Joints	**Y N** X– Ray/ Cobalt Treatment
Y N Congenital Heart Disorder	**Y N** Heart Murmur	**Y N** Parathyroid Disease	**Y N** Sexually Transmitted Disease
Y N Contact Lenses	**Y N** Heart Trouble/ Disease	**Y N** Psychiatric Care	

Are You:

Presently being treated for any other illness? Y N If yes, please explain:_____
Aware of any changes in your general health? Y N If yes, please explain:_____
Subject to frequent headaches? Y N If yes, please explain:_____
Often fatigued or exhausted? Y N Considered a touchy person? Y N
Often unhappy or depressed? Y N Easily upset or irritated? Y N
Males: Prostate Disorders Y N
FEMALES: Are you taking Birth Control pills? Y N
FEMALES: Pregnant? Y N If yes, How far along?:_____
FEMALES: Nursing? Y N
FEMALES: Are you taking hormone replacement? Y N If yes, Type and for?:_____
Do you have any condition not listed?_____

List any medications, supplements, and/or vitamins taken in last two years:

DRUG	PURPOSE	DRUG	PURPOSE

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform Harder Dental Corporation and any of their team members at my next visit. If deemed advisable, I grant permission for my physician to be contacted for further information and consultation. I grant permission for Harder Dental Corporation or their team members to contact any prior dentist to transfer any diagnostic records that may assist in my evaluation. CONSENT FOR TREATMENT: I hereby grant authority to Harder Dental Corporation or their team members whom are in charge of care for the patients name that appears on this Health History form, to administer such anesthetics, analgesics, sedatives and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. All services are rendered and accepted under the terms and conditions hereof: Authorization must be signed by the patient, or by guardian in case of minor or when patient is physically or mentally incompetent.

Signed:_____ **Date:**_____ **Relationship Patient:**_____

Doctors Signature:_____ **Date:**_____