Liza King D.M.D.
Patrick Carroll D.M.D.

Name_____ Date of Birth_____

MEDICAL HISTORY

Please mark (x) to your response to indicate if you have or have had any of the following:

Gastrointestinal
☐ Ulcers
☐ Gastrointestinal Disease
☐ Acid Reflux

Cardiovascular
☐ Angina (chest pain)
☐ Artificial Heart Valve
☐ Heart Conditions
☐ High/Low Blood Pressure
☐ Heart Surgery
☐ Pacemaker
☐ Stroke
☐ Heart Attack

Women
☐ Currently Pregnant
☐ Nursing

Respiratory
☐ Asthma
☐ Emphysema
☐ Respiratory Problems
☐ Sinus Problems
☐ Sleep Apnea
☐ Tuberculosis
☐ COPD

Musculoskeletal
☐ Arthritis
☐ Artificial Joints
☐ Jaw Joint Pain
☐ Rheumatoid Arthritis

Hematologic/Lymphatic
☐ Anemia
☐ Blood Disorders
☐ Bruise Easily
☐ Excessive Bleeding

Neurological
☐ Anxiety
☐ Depression
☐ Dizziness
☐ Drug/Alcohol Addiction
☐ Fainting
☐ Seizures
☐ Psychiatric Illness
☐ Autism

Endocrinology
☐ Diabetes
☐ Hepatitis A/B/C
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease

Viral Infections
☐ AIDS
☐ HIV Positive
☐ HPV

Cancer
Type_____
☐ Chemotherapy
☐ Radiation Therapy

Medical Allergies
☐ Antibiotics
_____
_____
☐ Latex
☐ Opioids
- Oxycodone
- Tylenol 3
- Percocet

☐ Local Anesthetics

Other Allergies:
_____
_____
_____

Any other medical concerns:_____

Primary Care Physician Name_____

Have you had a serious Illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain_____
_____

Are you taking or have you recently taken any prescription or over the counter medications? Y or N, If yes please list all, including vitamins, natural or herbal supplements and/or dietary supplements _____
_____
_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medication:_____

Have you ever had surgery? If so, what type:_____
_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient _____ Date _____