MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Date of last visit: _____ Have you had any serious illnesses or operations? Yes _____ No _____

If yes, briefly describe: _____

Please check if you presently have or have had in the past any of the following:

Yes	No		Yes	No		Yes	No	
0	0	Heart Disease	0	0	Ulcers	0	0	Sickle Cell Disease
0	0	Chest Pain (Angina)	0	0	Epilepsy or Seizures	0	0	Glaucoma
0	0	Heart Murmur	0	0	Diabetes	0	0	Arthritis
0	0	High Blood Pressure	0	0	Anemia	0	0	HIV Positive/AIDS
0	0	Low Blood Pressure	0	0	Asthma	0	0	Hepatitis
0	0	Prosthetic Joints	0	0	Other Lung Disease	0	0	Prolonged Bleeding
0	0	Kidney Problems	0	0	Allergies/Hives	0	0	Bruise Easily
0	0	Stroke	0	0	Sinus	0	0	Cancer
0	0	Thyroid Problems	0	0	Psychiatric Problems	0	0	Steroid Treatment

Is there any other condition the doctor should know about? _____

Please list any medications you are presently taking (including non-prescription medications):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medications that you are allergic to: (Penicillin, Aspirin, Local Anesthetics, etc.)

Have you ever had a general anesthetic before? Yes No

Did you eat or drink anything today? Yes No

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.

_____ _____

Patient or Authorized Guardian's Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the office of Richard P. Szumita, DDS to provide any insurance company(s), claim administrator(s), and consulting health care professional's information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of medical evaluation and administering claims for benefits.

_____ _____

Patient of Authorized Guardian's Signature **Date**