

**Medical History and Information for the  
Practice of Dr. Albert B. Boholst**

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Patient Name \_\_\_\_\_

**Do you have or have you ever had?**

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Low Blood Pressure            |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Mitral Valve Prolapse         |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> OTHER _____                   |

**Doctor's Notes**

(Do not write in this space)

Are you allergic to any medications, metals, or substances?  Yes  No  
If yes, which ones \_\_\_\_\_  
Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician?  Yes  No  
If yes, explain \_\_\_\_\_  
Physician's Name \_\_\_\_\_  
Address/Phone \_\_\_\_\_  
Female Patients: Are you pregnant?  
 Yes  No If yes, due date \_\_\_\_\_

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent of guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition and will notify the office of any changes in a timely manner.

**Payment for all treatment and services rendered are my responsibility.**

I authorize the use of my radiographs and/or photographs for use in seminars or publications of this dental office.

**X** \_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

