

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

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

