

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM - Please indicate corrections.

NAME (Last, First, Middle): _____ TITLE: _____

ADDRESS: _____

PREFERRED NAME: _____ SS NO: - - DOB: / /

HOME PHONE: () - _____ MARITAL: _____ REF. DOCTOR: _____

WORK PHONE: () - x _____ SEX: _____ REF. PATIENT: _____

EMAIL: _____

MEDICAL ALERTS: _____

Date of Last Physical Exam: / /

Are you now or have you recently been under a physician's care? ___ Yes ___ No

Reason: _____

Have you ever been a patient in a hospital or had any serious illness?

Explain: _____

Check any of the following that you have had or suspected:

- | | | |
|---|--|--|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Fainting Tendency |
| <input type="checkbox"/> <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Kidney/Bladder Trouble | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Lung Disease | <input type="checkbox"/> <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> <input type="checkbox"/> Prosthetic Joint Replacement |
| <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion |

Check any of the following that you are taking or have taken:

- | | | |
|---|--|---|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Drugs | <input type="checkbox"/> <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> <input type="checkbox"/> Steroids | <input type="checkbox"/> <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> <input type="checkbox"/> Sedatives |

Are you taking any other medication? ___ YES ___ NO If yes, explain: _____

Are you allergic to or do you suffer ill effects from any of the following?

- | | | |
|--|--|---|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Codeine | <input type="checkbox"/> <input type="checkbox"/> Dental Anesthesia |
| <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Household Bleach | <input type="checkbox"/> <input type="checkbox"/> Other: _____ |

Women Only:

Are you pregnant? ___ Yes ___ No If yes: How many months? _____ Are you breast feeding? _____

Are you presently taking medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy, etc.)

Explain: _____

The above information is true to the best of my knowledge.

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

Signature: _____

Please write any additional information on the back of this form - Thank you!