CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM - Please indicate corrections.

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

ADDRESS: _____

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

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

WORK PHONE: ( ) - x _____ SEX: M 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	
___	___	Arthritis	___	___	Hepatitis or Jaundice	___	___	Prolonged Bleeding
___	___	Rheumatic Fever	___	___	Liver Disease	___	___	Fainting Tendency
___	___	Heart Trouble	___	___	Cancer or Tumor	___	___	Epilepsy
___	___	Heart Murmur	___	___	Tuberculosis	___	___	Thyroid Disease
___	___	High/Low Blood Pressure	___	___	Diabetes	___	___	Glaucoma
___	___	Chest Pain	___	___	Kidney/Bladder Trouble	___	___	Radiation Treatment
___	___	Stroke	___	___	Anemia	___	___	Mental Disorders
___	___	Shortness of Breath	___	___	Lung Disease	___	___	HIV or AIDS
___	___	Asthma or Hay Fever	___	___	Venereal Disease	___	___	Prosthetic Joint Replacement
___	___	Sinus Trouble	___	___	Blood Disease	___	___	Blood Transfusion

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

YES	NO		YES	NO		YES	NO	
___	___	Cortisone Drugs	___	___	Anticoagulants	___	___	Tranquilizers
___	___	Steroids	___	___	Blood Thinners	___	___	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	
___	___	Penicillin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Aspirin	___	___	Household Bleach	___	___	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!