CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM - Please indicate corrections.

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ PREFERRED NAME: _____

HOME ADDRESS: _____

HOME: (___) ___-_____ WORK: (___) ___-_____ SS NO: ___-___-_____

DOB: ___/___/_____ MARITAL STATUS: ___ SEX: ___

REFERRING DOCTOR: _____ REFERRING PATIENT: _____

MEDICAL ALERTS: _____

MEDICAL HISTORY:

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:

___ 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?

___ 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!