Confidential Dental-Medical History

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

ADDRESS: _____

PREFFERED NAME: _____ SSN: _____-____-_____ DOB: _____

HOME PHONE: (___) ___-____ MARITAL STATUS: _____ REF. DOCTOR: _____

WORK PHONE: (___) ___-____ SEX: _____ REF. PATIENT: _____

CELL PHONE: (___) ___-____ EMAIL: _____

MEDICAL ALERTS: _____

_____

DATE OF LAST PHYSICAL: (Month/Year): ___/____

ARE YOU NOW OR HAVE YOU BEEN RECENTLY UNDER THE CARE OF A PHYSICIAN?

__YES __NO

REASON: _____

HAVE YOU EVER BEEN A PATIENT IN A HOSPITAL OR HAD ANY SERIOUS ILLNESS? __YES __NO

EXPLAIN: _____

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED:

__YES	__NO		__YES	__NO		__YES	__NO	
__	__	ARTHRITIS	__	__	HEPATITIS B	__	__	STROKE
__	__	RHEUMATIC FEVER	__	__	HEPATITIS C	__	__	CHEST PAIN
__	__	HEART MURMUR	__	__	SINUS TROUBLE	__	__	ANEMIA
__	__	HIGH/LOW PRESSURE	__	__	SHORTNESS OF BREATH	__	__	GLAUCOMA
__	__	RADIATION TREATMENT	__	__	PSYCHIATRIC DISORDERS	__	__	HIV OR AIDS
__	__	BLOOD TRANFUSION	__	__	HEART SURGERY	__	__	FAINTING
__	__	ASTHMA OR HAY FEVER	__	__	LUNG DISEASE	__	__	DIABETES

__YES __NO		__YES __NO	
__	__ LIVER DISEASE	__	__CANCER OR TUMOR
__	__TUBERCULOSIS	__	__ THYROID DISEASE
__	__AUTOIMMUNE DESEASE	__	__VENEREAL DISEASE
__	__ KIDNEY/BLADDER TROUBLE	__	__RECREATIONAL DRUGS
__	__BLOOD DISEASE	__	__ PROSTHETIC JOINT REPLACEMENT
__	__RECREATIONAL DRUGS	__	__ SMOKER /TOBACCO CHEWING

CHECK ANY OF THE FOLLOWING THAT YOU ARE TAKING OR HAVE TAKEN

__YES __NO		__YES __NO		__YES __NO	
__	__CORTISONE DRUGS	__	__STEROIDS DRUGS	__	__ SEDATIVES
__	__ANTI-DEPRESSANT	__	__BLOOD THINNERS		

ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING?

__YES __NO		__YES __NO	
__	__PENICILLIN	__	__CODEINE
__	__ASPIRIN	__	__DENTAL ANESTHESIA
__	__HOUSEHOLD BLEACH	__	__OTHER_____

IF YES, Explain: _____

_____

ARE YOU TAKING ANY OTHER MEDICATIONS? __YES __NO

IF YES, Explain: _____

WOMAN ONLY:

ARE YOU PREGNANT? __YES __NO IF YES, HOW MANY MONTHS? _____

ARE YOU BREASTFEEDING? __YES __NO

ARE YOU PRESENTLY TAKING MEDICINE OF ANY KIND ROUTINELY? (BIRTH CONTROL PILL, SHOTS OR IMPLANTS, HORMONE THERAPY, INCLUDING OVER –THE –COUNTER VITAMINS AND MINERALS.)

EXPLAIN: _____

_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEWDGE:

RESPONSIBLE PARTY FOR PATIENT:

NAME AND ADDRESS: _____

SIGNATURE: _____