CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM- Please indicate corrections.

NAME : _____ If patient is a minor Guardian/Parent Name:_____

ADDRESS: _____City_____ZIP_____

SOCIAL SECURITY NUMBER: _____ DOB: _____

HOME PHONE:_____CELL PHONE:_____

WORK PHONE:_____EMAIL:_____

MARITAL STATUS: _____ SEX:_____

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 ABNORMAL BLEEDING
YES NO ALLERGIES
YES NO ANEMIA
YES NO ANGINA PECTORIS
YES NO ARTHRITIS
YES NO ARTIFICIAL HEART
YES NO ARTIFICIAL JOINT
YES NO ASTHMA
YES NO BLOOD TRANSFUSION
YES NO CANCER/CHEMOTHERAPY
YES NO CHEST PAIN
YES NO CONGENITAL HEART DISEASE
YES NO DIABETES
YES NO DIFFICULTY BREATHING
YES NO DRUG ABUSE
YES NO EMPHYSEMA
YES NO EPILEPSY/SEIZURES
YES NO FAINTING SPELLS
YES NO FEVER BLISTERS
YES NO FREQUENT HEADACHES
YES NO GLAUCOMA
YES NO HIV/AIDS
YES NO HAY FEVER
YES NO HEART ATTACK
YES NO HEART SURGERY
YES NO HEMOPHILIA
YES NO HEPATITIS A
YES NO HEPATITIS B
YES NO HEPATITIS C
YES NO HERPES
YES NO HIGH BLOOD PRESSURE
YES NO KIDNEY PROBLEMS
YES NO LIVER DISEASE
YES NO LOW BLOOD PRESSURE
YES NO LUNG DISEASE
YES NO MITRAL VALVE
YES NO PACEMAKER
YES NO PSYCHIATRIC PROBLEMS
YES NO RADIATION THERAPY
YES NO RHEUMATIC FEVER
YES NO SHINGLES
YES NO SICKLE CELL DISEASE
YES NO SINUS PROBLEMS
YES NO STROKE
YES NO TAKING BISPHOSPHONATES
YES NO THYROID PROBLEMS
YES NO TUBERCULOSIS
YES NO VENEREAL DISEASE

Check any of the following that you are taking or have taken:
YES NO CORTISONE DRUGS YES NO ANTICOAGULANTS YES NO TRANQUILIZERS
YES NO STEROIDS YES NO BLOOD THINNERS YES NO SEDATIVES
Are you taking any other medication? YES NO If yes, please explain:_____

Are you allergic to or do you suffer ill effects from any of the following?
YES NO PENICILLIN YES NO CODEINE YES NO DENTAL ANESTHESIA
YES NO ASPIRIN YES NO HOUSEHOLD BLEACH YES NO OTHER:_____

WOMEN ONLY:
Are you pregnant or think you might be 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 implants, hormone therapy, etc.)
Explain:_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.
RESPOSNIBLE PARTY FOR PATIENT:

Name and Address:_____

Signature:_____ Date:_____