CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM-please indicate corrections

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

Place of birth: _____Date of birth: _____

Medical Alerts _____

MEDICAL HISTORY

Date of last Dental exam: _____
Reason for Dental visit today: _____
Date of last physical exam: _____
Are you now or have you recently been under a physicians care? ___Yes ___No
Reason: _____
Have you been a patient in a hospital or had any serious illness?
Explain: _____
Do you smoke: _____How often: _____

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

Yes	No	Yes	No	Yes	No
__	__ arthritis	__	__ hepatitis of jaundice	__	__ prolonged bleeding
__	__ rheumatic fever	__	__ liver disease	__	__ fainting tendency
__	__ heart murmur	__	__ cancer or tumor	__	__ epilepsy
__	__ diabetes	__	__ glaucoma	__	__ high/low blood pressure
__	__ chest pain	__	__ kidney/ bladder trouble	__	__ radiation treatment
__	__ stroke	__	__ anemia	__	__ mental disorders
__	__ shortness of breath	__	__ lung disease	__	__ HIV or AIDS
__	__ asthma	__	__ hay fever	__	__ venereal disease
__	__ blood transfusion	__	__ sinus trouble	__	__ blood disease
__	__ joint replacement				

Check any of the following that you are taken 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 __ Sulfa
__ 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: _____

RESPONSIBLE PARTY SIGNATURE: _____