

PATIENT'S HISTORY AND INFORMATION
(CONFIDENTIAL INFORMATION FOR OUR FILES)

DATE _____

(PLEASE PRINT CLEARLY)

NAME _____
LAST NAME MR. - MRS. - MISS FIRST NAME

SOC. SEC. NO. _____

BIRTH DATE _____

RES. ADDRESS _____
STREET CITY STATE ZIP

RES. PHONE _____

EMPLOYED BY _____

BUS. PHONE _____

BUS. ADDRESS _____
STREET CITY STATE ZIP

CELL PHONE _____

SPOUSE'S NAME _____

OCCUPATION _____

EMPLOYED BY _____

SPOUSE'S BUS. ADDRESS _____
STREET CITY STATE ZIP

SPOUSE'S BUS. PHONE _____

PERSON FINANCIALLY RESPONSIBLE _____
-DEPENDENTS ONLY-

NO. OF DEPENDENTS _____

RES. ADDRESS _____
STREET CITY STATE ZIP

RELATIONSHIP _____

NAME OF GROUP DENTAL PLAN _____

RES. PHONE _____

REFERRED BY _____

GROUP PLAN NO. _____

MEDICAL HISTORY

Name of Primary-Care Physician _____ Date Last Seen _____

Office Address _____ Zip _____ Phone _____

DO YOU OR HAVE YOU EVER HAD (check):

- | | |
|---|--|
| 1. Hospitalization for illness or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
(If yes, explain on back) | 28. Shunt / Stent <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Any allergies <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Lyme Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Any reaction to: | 30. Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Shortness of breath on mild exertion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Chest pains on mild exertion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. erythromycin <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Hives, skin rash, hay fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. codeine <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Psychiatric treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. sedatives or sleeping pills (barbiturates) <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. A tumor or abnormal growth <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. dental anesthetic <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. any other medication <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chemotherapy / Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Jaundice (yellow skin and eyes) <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Hearing Loss <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Prostate disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. HIV <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | ARE YOU: |
| 9. Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Presently being treated for any illness <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Taking any blood thinners <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Anemia or other blood disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Taking any medication regularly now or within
the past year, please list on the back <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Prolonged bleeding due to slight cut <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. Aware of any change in your general health
in the past year <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Aware of any recent weight change <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Often thirsty <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Stomach or duodenal ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No | 49. Urinating more than six times per day <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No | 50. Often exhausted and fatigued <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Subject to frequent headaches <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | 52. A heavy smoker:
(1 package or more of cigarettes per day) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Thyroid or parathyroid disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | 53. Generally a nervous person <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | 54. Often unhappy and depressed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | IF FEMALE, ARE YOU NOW: |
| 22. (M.V.P.) Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | 55. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | 56. Taking birth control pills or other hormones <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | 57. Presently in the menopause ("change of life") <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | 58. Past menopause <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Excessively swollen ankles <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 27. Hip or joint replacement <input type="checkbox"/> Yes <input type="checkbox"/> No | |

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS:

PLEASE LIST ALL MEDICATIONS

Patient's Signature _____ Date _____



MEDICAL HISTORY REVIEW UPDATES:

Patient's Signature _____ Date _____

Patient's Signature _____ Date _____

Patient's Signature _____ Date _____

Patient's Signature _____ Date _____