Today's Date:___/___/___

Name:_____ Date of Birth: ____/____/____

Address:_____ Phone #_____

Gender: □ Male □ Female Social Security # : _____

Height: _____ Weight: _____ Name of Physician: _____ Phone: _____

Employer:_____ Occupation:_____ Phone:_____

Referred by: _____ Email _____ Cell_____

Marital Status: _____ Name of Spouse: _____

Emergency Contact: _____ Phone: _____

Medical History (Please Circle)

Y N Heart trouble
Y N Rheumatic Fever/Rheumatic heart disease
Y N Heart Murmur/Congenital heart Defect
Y N Heart Attack/Stroke
Y N Irregular Heart Beat
Y N High Blood Pressure
Y N Ever been treated for osteoporosis with medication

Y N Pacemaker/Prosthetic Heart Valve
Y N Shortness of Breath/Chest Pain
Y N Asthma/Breathing Difficulties/Emphysema
Y N Epilepsy/Seizures/Convulsions

Y N Diabetes/Excessive Thirst
Y N Surgery/Radiation Treatment
Y N Cancer/Chemotherapy
Y N Addicted/Recovering from Drugs/Alcohol
Y N Ever denied permission to give blood
Y N AIDS/HIV Positive/ Immunocompromised

Y N Arthritis
Y N Stomach Ulcers
Y N Kidney Problems
Y N Tuberculosis
Y N Venereal Disease
Y N Psychiatric Therapy
Y N Eating Disorders / Digestive problems
Y N Thyroid Disease
Y N Blood Disorders
Y N Excessive bleeding after a cut
Y N Anemia/Bleeding
Y N Required a blood transfusion

Y N Hepatitis/Jaundice
Y N Glaucoma/Visual
Y N Artificial Bones/Joint Replacement
Y N Prosthetic Implant
Y N Any Transplant(s)
Y N Recent Weight Change
Y N Do your ankles swell?

Are you currently under the care of a physician? □Y or □ N
Describe condition: _____

Have you been hospitalized or had a serious illness within the past five years? □Y or □ N
Describe: _____

Are you taking any medication(s) including non-prescription medicine? □ Y or □ N

Medications: _____

_____

Has there been a change in your health within the last year? □ Yes □ No
Describe: _____

Are you allergic or had a reaction such as: itching, rash swelling of hands/feet/eyes to:
Novocaine/dental anesthetic? Codeine or other narcotics □ Latex Allergy? Penicillin ? Other _____?

ORAL HEALTH HISTORY

- History of fever blisters / cold sores / ulcers / canker sores? □Y or □ N
- Have you had any trouble with previous dental treatment? □Y or □ N
- Do you have any disease, condition, or problem not listed? □Y or □ N

If yes, please specify:_____

WOMEN

- Are you pregnant or anticipating pregnancy in the near future? □Y or □ N
- Are you taking birth control pills? □Y or □ N

SOCIAL HISTORY

- Do you smoke? □Y or □ N Do you use alcohol? □Y or □ N

I certify that I have read and understand the above. If I have any change in my health, or if my medications change, I will inform the doctor and his staff at the next appointment.

_____ _____

Signature of Patient/ Custodial Parent Date Signature of Doctor Date