PATIENT MEDICAL HISTORY

DATE _____

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have questions regarding your treatment, appointments, or fees, please feel free to ask. Your kindness in furnishing the following information will be appreciated. Please remember that the answers to these questions are held in strict confidence. NOTE: If patient is a minor, write name and relationship of responsible adult--address and occupation will pertain to responsible adult.

Patient Name: _____ ___ M ___ F
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP CODE

Phone Numbers: _____ _____ _____
HOME WORK CELL-Text? _____ yes
_____ no

May we call you at your work number to confirm your appointments? ____ yes ____ no

Marital Status: ___Single ___ Married ___ Widowed ___ Divorced

Date of Birth: _____ Social Security No.: _____

Physician's Name:_____ Physician's Phone: _____

Date of Last Physical Exam: _____

Person responsible for payment: _____ Address:_____

Employer: _____ Occupation: _____

1. Do you have, or have you ever had: (check any that apply)

___ heart murmur ___ mitral valve prolapse ___ rheumatic fever or rheumatic heart disease
___ heart ailment ___ high blood pressure
___ heart pacemaker ___ artificial heart valve or prosthesis
___ HIV/AIDS ___ ankle swelling ___ heart attack (if so, when _____)

___ respiratory or lung disease ___ diabetes ___ stomach or intestinal problem
___ tuberculosis ___ arthritis ___ stomach ulcer
___ asthma ___ stroke ___ thyroid problem
___ emphysema ___ hepatitis (type: _____) ___ yellow jaundice
___ fainting or seizures ___ anemia ___ glaucoma
___ sinus trouble ___ kidney disease ___ allergy
___ persistent cough ___ liver disease ___ venereal disease or syphilis
___ recurrent sore throat ___ hormone deficiency
___ tumor or growth, and if so, what kind _____
___ any blood disease, and if so, what kind _____
___ joint replacement, and if so, what kind and when _____

2. Are you under medical treatment now? ___ yes ___ no
(If yes, please explain: _____)

3. Have you had any major operations? ___ yes ___ no
(If yes, please explain: _____)

4. Other than major operations listed above, have you been hospitalized within the last five (5) years? ___ yes ___ no
(If yes, please explain: _____)

5. Have you had abnormal bleeding after cuts, surgery, or dental extractions? ___ yes ___ no

6. Are you employed anywhere that exposes you to x-rays or ionizing radiation? ___ yes ___ no

7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ___ yes ___ no
(If yes, please explain: _____)

8. Are you now taking any drugs/medicines, including over-the-counter? ___ yes ___ no
(If yes, please list: _____)

9. Are you allergic to, or have you ever reacted adversely to: (check any that apply)

___ penicillin	___ sulfa drugs	___ codeine
___ erythromycin	___ aspirin	___ latex
___ sedatives, barbiturates, or sleeping pills		___ metals
___ other: _____		___ dyes

10. Are you in good health at this time? ____ yes ____ no

11. Women: Are you pregnant? ___ yes ___ no If yes, due date? _____

12. How did you choose this office for your dental care? ___ yellow page ad ___ location/sign
___ referred by _____
___ other _____

13. What are your dental complaints at this time? _____

14. When were your last full-mouth x-rays taken? _____

15. Have you ever had an allergic reaction or problem associated with the use of a local anesthetic (such as Novocain)? If so, please explain: _____

16. Is there any dental condition or previous difficulty with dental treatment that your dentist should know about before undertaking treatment? If so, please explain: _____

17. Have you ever been told that you need antibiotics before dental treatment? ____ yes ____ no