

MEDICAL HISTORY

Patient's Name _____ Birth Date ____/____/____ SS# _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently.

INCORRECT INFORMATION CAN BE DANGEROUS TO YOUR HEALTH

****Write the answer to each question in the space provided****

****All questions must be answered.****



Name of Physician _____ Phone # _____

Address _____ Date of Last Visit _____

Reason for Last Visit _____

1. Are you currently under the care of a Physician?.....() Yes () No

If "YES", for what reason or condition? _____

2. Are you currently taking any medications?.....() Yes () No

If "YES", what medication, and for what reason or condition? _____

HAVE YOU EVER HAD TREATMENT FOR:

3. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?....() Yes () No

4. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?.....() Yes () No

5. Have you ever taken Phen phen?.....() Yes () No

6. Abnormal blood pressure, excessive bleeding, or anemia?.....() Yes () No

7. Breathing problems, asthma, tuberculosis, or hay fever?.....() Yes () No

8. Cancer, radiation treatments, or chemotherapy?.....() Yes () No

9. Diabetes?.....() Yes () No

10. Hepatitis, jaundice, or liver disease?.....() Yes () No

- 11. Kidney problems or renal dialysis?.....() Yes () No
- 12. AIDS?.....() Yes () No
- 13. Arthritis or rheumatism?.....() Yes () No
- 14. Allergic reactions to medications?.....() Yes () No
- 15. Have taken steroids in the last year?.....() Yes () No
- 16. Have you ever had surgery?.....() Yes () No

If "YES", explain. _____

- 17. Have you ever had a serious injury to your head or neck?.....() Yes () No

If "Yes", explain. _____

- 18. Do you smoke?.....() Yes () No

- 19. Have you consulted or been treated by a psychiatrist, psychologist, or counselor?.....() Yes () No

If "Yes", explain. _____

- 20. Are there any other problems about your health of which you are aware?.....() Yes () No

If "Yes", explain. _____

- 21. FOR WOMEN: Are you pregnant?.....() Yes () No

Blood Pressure: _____



NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, all the questions on this form have been accurately answered.

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

Signature of responsible party

Date Form Signed & Completed

Print Name

Relationship, if other than patient

I give the dentist permission to take photographs to use for educational and promotional purposes.

Signature

Date

Signature of Dr.

Date