(PLEASE PRINT CLEARLY)

PATIENT'S HISTORY AND INFORMATION

(CONFIDENTIAL INFORMATION FOR OUR FILES)

DATE _____

SOC. SEC. NO. _____

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

RES. ADDRESS _____ RES. PHONE _____
STREET CITY STATE ZIP

EMPLOYED BY _____ BUS. PHONE _____

BUS. ADDRESS _____ CELL PHONE _____
STREET CITY STATE ZIP

SPOUSE'S NAME _____ OCCUPATION _____

EMPLOYED BY _____

SPOUSE'S BUS. ADDRESS _____ SPOUSE'S BUS. PHONE _____
STREET CITY STATE ZIP

PERSON FINANCIALLY RESPONSIBLE _____ NO. OF DEPENDENTS _____
-DEPENDENTS ONLY-

RES. ADDRESS _____ RELATIONSHIP _____
STREET CITY STATE ZIP

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 ❑ Yes ❑ No
   (If yes, explain on back)
2. Any allergies ❑ Yes ❑ No
3. **Any reaction to:**
   a. aspirin ❑ Yes ❑ No
   b. penicillin ❑ Yes ❑ No
   c. erythromycin ❑ Yes ❑ No
   d. tetracycline ❑ Yes ❑ No
   e. codeine ❑ Yes ❑ No
   f. sedatives or sleeping pills (barbiturates) ❑ Yes ❑ No
   g. dental anesthetic ❑ Yes ❑ No
   h. any other medication ❑ Yes ❑ No
4. Hepatitis ❑ Yes ❑ No
5. Jaundice (yellow skin and eyes) ❑ Yes ❑ No
6. Epilepsy ❑ Yes ❑ No
7. Arthritis ❑ Yes ❑ No
8. Herpes ❑ Yes ❑ No
9. Rheumatic fever ❑ Yes ❑ No
10. Scarlet fever ❑ Yes ❑ No
11. Anemia or other blood disorders ❑ Yes ❑ No
12. Prolonged bleeding due to slight cut ❑ Yes ❑ No
13. Kidney disease ❑ Yes ❑ No
14. Diabetes ❑ Yes ❑ No
15. Stomach or duodenal ulcer ❑ Yes ❑ No
16. Liver disease ❑ Yes ❑ No
17. Tuberculosis ❑ Yes ❑ No
18. Respiratory Disease ❑ Yes ❑ No
19. Thyroid or parathyroid disorders ❑ Yes ❑ No
20. Heart trouble ❑ Yes ❑ No
21. Heart murmur ❑ Yes ❑ No
22. (M.V.P.) Mitral Valve Prolapse ❑ Yes ❑ No
23. Arteriosclerosis ❑ Yes ❑ No
24. High blood pressure ❑ Yes ❑ No
25. Low blood pressure ❑ Yes ❑ No
26. Excessively swollen ankles ❑ Yes ❑ No
27. Hip or joint replacement ❑ Yes ❑ No
28. Shunt / Stent ❑ Yes ❑ No
29. Lyme Disease ❑ Yes ❑ No
30. Stroke ❑ Yes ❑ No
31. Shortness of breath on mild exertion ❑ Yes ❑ No
32. Chest pains on mild exertion ❑ Yes ❑ No
33. Hives, skin rash, hay fever ❑ Yes ❑ No
34. Asthma ❑ Yes ❑ No
35. Psychiatric treatment ❑ Yes ❑ No
36. A tumor or abnormal growth ❑ Yes ❑ No
37. Dialysis ❑ Yes ❑ No
38. Chemotherapy / Radiation ❑ Yes ❑ No
39. Glaucoma ❑ Yes ❑ No
40. Hearing Loss ❑ Yes ❑ No
41. Prostate disorders ❑ Yes ❑ No
42. HIV ❑ Yes ❑ No

ARE YOU:

43. Presently being treated for any illness ❑ Yes ❑ No
44. Taking any blood thinners ❑ Yes ❑ No
45. Taking any medication regularly now or within the past year, please list on the back ❑ Yes ❑ No
46. Aware of any change in your general health in the past year ❑ Yes ❑ No
47. Aware of any recent weight change ❑ Yes ❑ No
48. Often thirsty ❑ Yes ❑ No
49. Urinating more than six times per day ❑ Yes ❑ No
50. Often exhausted and fatigued ❑ Yes ❑ No
51. Subject to frequent headaches ❑ Yes ❑ No
52. A heavy smoker:
    (1 package or more of cigarettes per day) ❑ Yes ❑ No
53. Generally a nervous person ❑ Yes ❑ No
54. Often unhappy and depressed ❑ Yes ❑ No

IF FEMALE, ARE YOU NOW:

55. Pregnant ❑ Yes ❑ No
56. Taking birth control pills or other hormones ❑ Yes ❑ No
57. Presently in the menopause ("change of life") ❑ Yes ❑ No
58. Past menopause ❑ Yes ❑ No

-OVER-

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 _____