

MEDICAL DENTAL HISTORY

Name _____

DATE OF BIRTH _____ AGE _____ DATE OF LAST HEALTH CARE EXAMINATION _____

FOR WHAT _____

HAVE YOU BEEN HOSPITALIZED IN LAST 5 YEARS? _____ IF SO, FOR WHAT? _____

NAME OF YOUR PHYSICIAN _____

ARE YOU RECEIVING OTHER HEALTH CARE NOW? _____ IF SO, NATURE OF CARE _____

DO YOU HAVE OR HAVE YOU EVER HAD:

TOBACCO USE: SMOKER _____ HOW OFTEN? _____
 SNUFF/DIP _____ HOW LONG? _____

- | | | |
|---|--|---|
| <p>YES NO</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE/HEPATITIS A, B, C</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> DIABETES</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> EPILEPSY</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER/SCARLET FEVER</p> <p>5. <input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS</p> <p>6. <input type="checkbox"/> <input type="checkbox"/> ASTHMA</p> <p>7. <input type="checkbox"/> <input type="checkbox"/> LUNG DISEASE</p> <p>8. <input type="checkbox"/> <input type="checkbox"/> HEART ATTACK/STROKE</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> GLAUCOMA</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> PROLONGED BLEEDING</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> RADIATION TREATMENT</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> ANEMIA</p> <p>13. <input type="checkbox"/> <input type="checkbox"/> ARTHRITIS</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV POSITIVE</p> <p>15. <input type="checkbox"/> <input type="checkbox"/> HERPES VIRUS-COLD SORES</p> | <p>YES NO</p> <p>16. <input type="checkbox"/> <input type="checkbox"/> ANY HEART PROBLEM</p> <p>17. <input type="checkbox"/> <input type="checkbox"/> THYROID DISORDER</p> <p>18. <input type="checkbox"/> <input type="checkbox"/> RINGING IN EARS</p> <p>19. <input type="checkbox"/> <input type="checkbox"/> A BLOOD PRESSURE PROBLEM</p> <p>20. <input type="checkbox"/> <input type="checkbox"/> CANCER or TUMORS</p> <p>21. <input type="checkbox"/> <input type="checkbox"/> WOMEN: ARE YOU PREGNANT?</p> <p>22. <input type="checkbox"/> <input type="checkbox"/> CHRONIC SINUSITIS</p> <p>23. <input type="checkbox"/> <input type="checkbox"/> HEAD & NECK PAIN</p> <p>24. <input type="checkbox"/> <input type="checkbox"/> JAUNDICE</p> <p>25. <input type="checkbox"/> <input type="checkbox"/> MITRAL VALVE PROLAPSE/HEART MURMUR</p> <p>26. <input type="checkbox"/> <input type="checkbox"/> V.D./SYPHILLIS</p> <p>27. <input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASE</p> <p>28. <input type="checkbox"/> <input type="checkbox"/> PSYCHIATRIC TREATMENT</p> <p>29. <input type="checkbox"/> <input type="checkbox"/> TAKEN PHEN-FEN</p> <p>30. <input type="checkbox"/> <input type="checkbox"/> FAINTING OR DIZZY SPELLS, INCL. UNFAVORABLE REACTION TO DENTAL TREATMENT</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> ALLERGIES OR SENSITIVITIES (such as nausea)</p> <p><input type="checkbox"/> <input type="checkbox"/> PENICILLIN <input type="checkbox"/> ASPIRIN</p> <p><input type="checkbox"/> <input type="checkbox"/> ERYTHROMYCIN <input type="checkbox"/> LOCAL ANESTHETIC</p> <p><input type="checkbox"/> <input type="checkbox"/> CODEINE <input type="checkbox"/> OTHER (TALC, POLLEN)</p> <p>ALLERGIC TO:</p> <p><input type="checkbox"/> <input type="checkbox"/> LATEX <input type="checkbox"/> <input type="checkbox"/> JEWELRY</p> <p>DO YOU NOW HAVE (CHECK IF YES)</p> <p><input type="checkbox"/> <input type="checkbox"/> TOOTHACHE</p> <p><input type="checkbox"/> <input type="checkbox"/> ARTIFICIAL JOINTS OR LIMBS</p> <p><input type="checkbox"/> <input type="checkbox"/> BROKEN FILLINGS</p> <p><input type="checkbox"/> <input type="checkbox"/> FREQUENT HEADACHES</p> <p><input type="checkbox"/> <input type="checkbox"/> PROSTHETIC HEART VALVES</p> <p><input type="checkbox"/> <input type="checkbox"/> A DRUG ABUSE PROBLEM</p> <p><input type="checkbox"/> <input type="checkbox"/> AN ULCER</p> |
|---|--|---|

IF ALLERGIES TO MEDICATIONS OR DRUGS, INDICATE WHICH ONES _____

ARE YOU TAKING ANY MEDICATION? _____ IF SO, WHAT? _____

OTHER PHYSICAL CONDITIONS: _____

IF NEW ADDRESS OR _____

PHONE #, PLEASE LIST _____

IF NEW EMPLOYER OR INSURANCE COVERAGE, PLEASE LIST BELOW: (For Self or Spouse)

EMPLOYEE NAME _____ EMPLOYER _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____

INSURANCE CO. _____ INS. CO. _____

POLICY # _____ ADDRESS _____

GROUP # _____

EMPLOYEE SS# _____

I certify that the above information is complete and accurate.

 PATIENT'S SIGNATURE DATE

MEDICAL UPDATE:				
CONDITION	DATE	MEDICATIONS	DOSAGE	DATE OF CHANGE

MED. ALERT