# CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

NAME: (Last, First, Middle)____________________________ TITLE:_______________________
ADDRESS________________________________________________________________________
PREFERRED NAME_________________ SS NO___________________ DOB_______________
HOMEPHONE_____________________ MARITAL________ REF. DOCTOR_______________
WORK PHONE______________________ SEX__________ REF. PATIENT_________________
EMAIL: __________________________________________________________________________
MEDICAL ALERTS:_______________________________________________________________
Date of Last Physical Exam:
Are you now or have you recently been under a physician's care?____Yes____No
Reason:__________________________________________________________________________
Have you ever been a patient in a hospital or had any serious illness?
Explain:_______________________________________________________________________
Check any of the following that you have had or suspected:

| YES NO | YES NO | YES NO |
|---|---|---|
| ----- ----- Arthritis | ----- ----- Hepatitis or Jaundice | ----- ----- Prolonged Bleeding |
| ----- ----- Rheumatic Fever | ----- ----- Liver Disease | ----- ----- Fainting Tendency |
| ----- ----- Heart Trouble | ----- ----- Cancer or Tumor | ----- ----- Epilepsy |
| ----- ----- Heart Murmur | ----- ----- Tuberculosis | ----- ----- Thyroid Disease |
| ----- ----- High/Low Blood Pressure | ----- ----- Diabetes | ----- ----- Glaucoma |
| ----- ----- Chest Pain | ----- ----- Kidney/Bladder Trouble | ----- ----- Radiation Treatment |
| ----- ----- Stroke | ----- ----- Anemia | ----- ----- Mental Disorders |
| ----- ----- Shortness of Breath | ----- ----- Lung Disease | ----- ----- HIV or AIDS |
| ----- ----- Asthma or Hay Fever | ----- ----- Venereal Disease | ----- ----- Prosthetic Joint Replacement |
| ----- ----- Sinus Trouble | ----- ----- Blood Disease | ----- ----- Blood Transformation |

Check any of the following that you are taking or have taken:

| YES NO | YES NO | YES NO |
|---|---|---|
| ----- ----- Cortisone Drugs | ----- ----- Anticoagulants | ----- ----- Tranquilizers |
| ----- ----- Steroids | ----- ----- Blood Thinners | ----- ----- Sedatives |

Are you taking any other medication?____YES____NO If yes, explain:____________________________________________
Are you allergic to or do you suffer ill effects from any of the following?

| YES NO | YES NO | YES NO |
|---|---|---|
| ----- ----- Penicillin | ----- ----- Codiene | ----- ----- Dental Anesthesia |
| ----- ----- Aspirin | ----- ----- Household Bleach | ----- ----- Other_______________ |

Women Only:
Are you pregnant?___ Yes___ No If yes, How many months?______________ Are you breastfeeding?________________
Are you presently taking any medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy, etc.,)
Explain:___________________________________________________________________________________________

**The above information is true to the best of my knowledge.**
**RESPONSIBLE PARTY FOR PATIENT:**
Name and Address:_________________________________________________________________________________
Signature:_________________________________________________________________________________________