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Patient Medical History

Physician Name: ______________________ Phone: ______________________

Address: ____
Street *City* *CA* *Zip*

Your current physical health is: Good Fair Poor When was your last physical? ______________

Have you ever experienced any of the following symptoms or procedures? (Circle Yes or No):

Abnormal Bleeding	Y	N	Frequently Nervous	Y	N	Sleep Deprivation from Pain	Y	N
Anemia	Y	N	General or Local Anesthetic	Y	N	Stomach trouble	Y	N
Arthritis	Y	N	Head X-ray / Radiation Therapy	Y	N	Frequent Sore Throats	Y	N
Asthma	Y	N	Heart trouble	Y	N	Frequent Toothaches	Y	N
Back / Neck Pain	Y	N	Hepatitis	Y	N	Seizures	Y	N
Blood Disorder	Y	N	High Blood Pressure	Y	N	Short of Breath Easily	Y	N
Chicken Pox	Y	N	Hives or Skin Rash	Y	N	Stroke	Y	N
Depression	Y	N	Jaundice	Y	N	Surgery / Operation	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Swollen Ankles	Y	N
Dizzy Spells	Y	N	Lung Disease	Y	N	Syphilis / Gonorrhea	Y	N
Drink Alcohol Daily	Y	N	Kidney / Bladder Trouble	Y	N	Tired Jaw After Chewing	Y	N
Ear Pain	Y	N	Measles	Y	N	Thyroid Disease	Y	N
Easily Upset	Y	N	Mumps	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	Rheumatic Fever	Y	N	Ulcers	Y	N
Frequent / Severe Headaches	Y	N	Sinus Problems	Y	N	Venereal Disease	Y	N

Please elaborate on any of the above, where necessary: ______________________

____

List any serious medical condition(s) you have had, NOT listed above: ______________________

____

GIRLS	Has menstruation begun?	Y	N	BOYS Has puberty begun?	Y	N
WOMEN	Are you pregnant?	Y	N	Are you currently in, or have you passed through menopause?	Y	N

Has there been any change in your health in the last year, including considerable weight loss & gain? Describe.

____

Other than corrective glasses, have you ever been treated for eye or ear trouble? Y N

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Allergies

Is the patient sensitive or allergic to any of the following?

Aspirin	Y	N	Erythromycin	Y	N	Penicillin	Y	N
Codeine	Y	N	Latex	Y	N	Plastics	Y	N
Dental Anesthetics	Y	N	Metals	Y	N	Tetracycline	Y	N

Please list any other drugs / materials that you are allergic to: ______________

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Drugs & Medications

Please list all prescription and non-prescription drugs taken or used in the past three months: __________

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Thank you for filling out this form completely.

By signing, I agree that information I have given today is correct to the best of my knowledge. I also understand that this information is held in the strictest confidence, as described in the Notice of Privacy Practices given to me. I recognize that it is my responsibility to inform this office of any changes in my medical status. I understand that when appropriate, credit bureau reports may be obtained. Furthermore, I authorize this staff to perform any necessary dental services that I may need during diagnosis and treatment *with my informed consent.*

______________________ ______________________ ______________________
Responsible Party Name *Signature* *Date*

Office Use	Medical / dental information reviewed with patient named herein.	Initials:	Date:

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