

**PATIENT'S HISTORY AND INFORMATION**  
(CONFIDENTIAL INFORMATION FOR OUR FILES)

DATE \_\_\_\_\_

**(PLEASE PRINT CLEARLY)**

NAME \_\_\_\_\_  
LAST NAME MR. - MRS. - MISS FIRST NAME

SOC. SEC. NO. \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

RES. ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

RES. PHONE \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_

BUS. PHONE \_\_\_\_\_

BUS. ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

CELL PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_

SPOUSE'S BUS. ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

SPOUSE'S  
BUS. PHONE \_\_\_\_\_

PERSON FINANCIALLY RESPONSIBLE \_\_\_\_\_  
-DEPENDENTS ONLY-

NO. OF DEPENDENTS \_\_\_\_\_

RES. ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

RELATIONSHIP \_\_\_\_\_

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 ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(If yes, explain on back) | 28. Shunt / Stent ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 2. Any allergies ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 29. Lyme Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 3. <b>Any reaction to:</b>  | 30. Stroke ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| a. aspirin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 31. Shortness of breath on mild exertion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| b. penicillin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 32. Chest pains on mild exertion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| c. erythromycin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 33. Hives, skin rash, hay fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| d. tetracycline ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 34. Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| e. codeine ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 35. Psychiatric treatment ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| f. sedatives or sleeping pills (barbiturates) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | 36. A tumor or abnormal growth ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| g. dental anesthetic ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 37. Dialysis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| h. any other medication ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 38. Chemotherapy / Radiation ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 4. Hepatitis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 39. Glaucoma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 5. Jaundice (yellow skin and eyes) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                     | 40. Hearing Loss ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 6. Epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 41. Prostate disorders ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 7. Arthritis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 42. HIV ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 8. Herpes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | <b>ARE YOU:</b>  |
| 9. Rheumatic fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 43. Presently being treated for any illness ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10. Scarlet fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 44. Taking any blood thinners ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 11. Anemia or other blood disorders ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                    | 45. Taking any medication regularly now or within<br>the past year, please list on the back ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Prolonged bleeding due to slight cut ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                               | 46. Aware of any change in your general health<br>in the past year ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          |
| 13. Kidney disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 47. Aware of any recent weight change ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 14. Diabetes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 48. Often thirsty ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 15. Stomach or duodenal ulcer ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 49. Urinating more than six times per day ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 16. Liver disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 50. Often exhausted and fatigued ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 17. Tuberculosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 51. Subject to frequent headaches ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 18. Respiratory Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 52. A heavy smoker:<br>(1 package or more of cigarettes per day) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            |
| 19. Thyroid or parathyroid disorders ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                   | 53. Generally a nervous person ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 20. Heart trouble ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 54. Often unhappy and depressed ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 21. Heart murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | <b>IF FEMALE, ARE YOU NOW:</b>   |
| 22. (M.V.P.) Mitral Valve Prolapse ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                     | 55. Pregnant ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 23. Arteriosclerosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 56. Taking birth control pills or other hormones ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 24. High blood pressure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 57. Presently in the menopause ("change of life") ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Low blood pressure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 58. Past menopause ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 26. Excessively swollen ankles ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 27. Hip or joint replacement ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |

**PLEASE EXPLAIN FULLY ANY "YES" ANSWERS:**

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**PLEASE LIST ALL MEDICATIONS**

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Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_



**MEDICAL HISTORY REVIEW UPDATES:**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_