CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM - Please indicate corrections. LAST NAME: _____ TITLE: ____ FIRST NAME: ____ MIDDLE NAME: PREFERRED NAME: HOME ADDRESS: HOME: () CELL:() WORK: () SOCIAL SECURITY #: - -DATE OF BIRTH / / MARTIAL STATUS: ____ SEX___ REFERRING DOCTOR/PATIENT: ____ MEDICAL ALERTS: MEDICAL HISTORY: Date of Last Physical Exam: ____/_/ Are you now or have you recently been under a physician's care? Yes No Have you ever been a patient in a hospital or had any serious illness? 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 ___ Heart Murmur ___ Cancer or Tumor ___ Epilepsy ___ Tuberculosis ____ Thyroid Disease High/Low Blood Pressure Diabetes ___ Glaucoma ____ Radiation Treatment ___ Kidney/Bladder Trouble ___ Chest Pain ___Stroke ____ Mental Disorders ___ Anemia ____ HIV or AIDS ___ Shortness of Breath ___ Lung Disease ____ Venereal Disease ____ Prosthetic Joint Replacement ____ Asthma or Hay Fever ___ Sinus Trouble ____ Blood Disease ____ Blood Transfusion Check any of the following that you are taking or have taken: ___ 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 effect from any of the following? ___ Penicillin ___ Codeine ___ Dental Anesthesia ____ Aspirin ____ Household Bleach ____ Other: ____ Women Only: Are you pregnant? ___ Yes ___ No If yes: How many months? ____ Are you breast feeding? _ Are you presently taking 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: