

CONFIDENTIAL MEDICAL HISTORY FORM

LAST NAME: _____ TITLE: _____ FIRST NAME: _____
DOB: _____ SEX: _____

MEDICAL HISTORY:

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, Rheumatism | ___ ___ 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 Transfusion |
| ___ ___ Frequent Headache | ___ ___ Chemical Dependency, Drug Abuse | ___ ___ Chemo- or Radiation Therapy |

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

- | | | |
|---------------------------------|---------------------------------|-----------------------|
| YES NO | YES NO | YES NO |
| ___ ___ Cortisone/Steroid Drugs | ___ ___ Anticoagulants | ___ ___ Tranquilizers |
| ___ ___ Fen-Phen, Diet Pills | ___ ___ Blood Thinners, Aspirin | ___ ___ Sedatives |

Are you taking any 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, Amoxicillin | ___ ___ Erythromycin, Azithromycin, Biaxin | ___ ___ Tetracycline, Doxycycline |
| ___ ___ Codeine | ___ ___ Aspirin, Ibuprofen, NSAIDs | ___ ___ Novocain, Lidocaine |
| ___ ___ Household Bleach | ___ ___ Nickel | ___ ___ Latex |
| ___ ___ 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. I will not hold my dentist or member of his/her staff responsible for any harms or ill effects that may arise due to any errors or omissions that I may have made in completing this form

Name and Address of Responsible Party: _____

Signature: _____ Date: _____ Reviewed by: _____

*****For Future Medical History Updates*****

- | | | |
|----------------|-------------|--------------------|
| Updated: _____ | Date: _____ | Reviewed by: _____ |
| Updated: _____ | Date: _____ | Reviewed by: _____ |
| Updated: _____ | Date: _____ | Reviewed by: _____ |
| Updated: _____ | Date: _____ | Reviewed by: _____ |