

PATIENT INFORMATION

Patient Name: _____ **Date:** ____/____/____

First MI Last

Gender: M / F **Married:** Yes / No **Date of Birth:** ____/____/____ **SSN:** _____

Patient Address: _____ **City, State, Zip:** _____

Home Tel: () _____ - _____ **Work:** () _____ - _____ ext _____ **Cell:** () _____ - _____

Email Address: _____ **Referred by:** _____

Physician – Name & Phone Number: _____ **Pharmacy Phone Number:** _____

Emergency Contact – Name & Phone Number : _____

Dental Insurance Carrier: _____ **Employer:** _____

HEALTH INFORMATION

If you have or ever had any of the following diseases, please check Yes or No the listed below.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus / Nasal Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clicking or Popping of Jaw Joint |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Adverse effects from dental treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV / Hepatitis / Sexual Transmitted Diseases |
| | <u>Cardiovascular Disease: CIRCLE ONE</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recurrent infections of any kind |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur, Stroke, Pace Maker, Angina, Coronary Artery Disease, Heart Attack, Heart Trouble, Palpitations, Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors |
| | <u>Lung Disease: CIRCLE ONE</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any reason for depressed immune system |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma, Emphysema, Bronchitis, Pneumonia, Tuberculosis, Chest Pain, Chronic Coughing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Disorder |
| | <u>CIRCLE ONE</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures, Convulsions, Epilepsy, Fainting; Dizziness, or Panic Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorder, Anemia, Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease : Jaundice, Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke or chew tobacco? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints / Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use alcohol? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you using a controlled substance? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had any serious illnesses, operations, or hospitalizations? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease (Goiter) | | Please describe: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | FOR WOMEN ONLY | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers / Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments for Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you using oral contraceptives? |

Yes No Are you using or taking any medications (including over the counter) medication?
If yes, please list: _____

Yes No Are you allergic or have had a bad reaction to any medications?
If yes, please list: _____

Are you under a Physician’s care for a particular reason? Y / N Date of last physical exam? _____

Please list any conditions or problems not listed above that you would like to speak with the doctor about: _____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Patient /Guardian Signature: _____ Date _____

