CONFIDENTIAL MEDICAL HISTORY

Please check ✔ or use block letter

FILE NUMBER

REFERENCE: _____

PATIENT'S FAMILY NAME	FIRST NAME	DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE

ADDRESS (Street, No., Apt)	CITY	POSTAL CODE

HOME TELEPHONE	OFFICE TELEPHONE	MOBILE PHONE	OTHER PHONE	EMAIL ADDRESS

HAVE YOU HAD PROBLEMS WITH YOUR GENERAL HEALTH WITHIN THE LAST 5 YEARS? ☐ Yes ☐ No

ANY SERIOUS ILLNESS? ☐ Yes ☐ No DATE OF LAST MEDICAL CHECK-UP _____ / _____ / _____ (YEAR / MONTH / DAY)

WERE YOU ALREADY HOSPITALIZED? ☐ Yes ☐ No

If YES, for what reason? _____ Frequency _____

ARE YOU UNDER A PHYSICIAN'S CARE NOW? ☐ Yes ☐ No

If YES, specify _____

NAME OF YOUR DOCTOR: _____ TEL. (R) _____ (B) _____

FREQUENCY: _____ WHY? _____

CONFIDENTIAL DENTAL HISTORY

REASON FOR THIS VISIT ☐ Regular Visit ☐ Emergency Only ☐ Other: _____

ANY DISCOMFORT OR PAIN? ☐ Yes ☐ No If YES, where? _____

IF YOU ARE A **NEW PATIENT**,
SPECIFY DATE OF LAST DENTAL VISIT _____ / _____ / _____ (YEAR / MONTH / DAY) TREATMENT RECEIVED AT THAT TIME: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

RHEUMATIC FEVER RHEUMATIC DISEASE	☐ Yes	☐ No	SKIN DISEASE	☐ Yes	☐ No
HEART TROUBLE, HEART ATTACK, HIGH BLOOD PRESSURE STROKE	☐ Yes	☐ No	TUBERCULOSIS AND ANY OTHER LUNG DISEASE	☐ Yes	☐ No
PAIN IN CHEST SHORTNESS OF BREATH SWOLLEN ANKLES	☐ Yes	☐ No	PERSISTENT COUGH AND COUGHING UP BLOOD	☐ Yes	☐ No
BLOOD DISORDERS ANEMIA	☐ Yes	☐ No	LOCAL ANESTHETICS	☐ Yes	☐ No
BLOOD TEST WITH UNUSUAL RESULT	☐ Yes	☐ No	EPILEPSY	☐ Yes	☐ No
ABNORMAL BLEEDING, PROLONGED HEALING, BRUISING EASILY	☐ Yes	☐ No	SINUSITIS	☐ Yes	☐ No
ASTHMA, HAY FEVER	☐ Yes	☐ No	VENEREAL DISEASES	☐ Yes	☐ No
LOW BLOOD PRESSURE	☐ Yes	☐ No	DIABETES	☐ Yes	☐ No
FAINTING SPELLS SEIZURES	☐ Yes	☐ No	MONONUCLEOSIS	☐ Yes	☐ No
LIVER TROUBLE (HEPATITIS A, B, C, OF CIRRHOSIS)	☐ Yes	☐ No	RADIATION TREATMENT TUMORS OR SORES THAT DID NOT HEAL WITHIN ONE WEEK	☐ Yes	☐ No
ARTHRITIS	☐ Yes	☐ No			
KIDNEY TROUBLES	☐ Yes	☐ No	DO YOU HAVE PROTHETIC JOINTS	☐ Yes	☐ No
HIV POSITIVE	☐ Yes	☐ No	MIGRAINE OR PAIN IN HEAD EAR TROUBLE ANXIETY	☐ Yes	☐ No
DIGESTIVE TROUBLE	☐ Yes	☐ No	WOMEN: ARE YOU PREGNANT?	☐ Yes	☐ No
DO YOU SMOKE?	☐ Yes	☐ No	ARE YOU IN MENOPAUSE?	☐ Yes	☐ No
THYROIDE TROUBLE	☐ Yes	☐ No	DO YOU TAKE AN ORAL CONTRACEPTIVE	☐ Yes	☐ No

ARE YOU TAKING ANY MEDICATION? ☐ Yes ☐ No ☐ Aspirin ☐ Vitamin ☐ Other ☐ Allergy to Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Others

MEDICATION	SPECIAL CONSIDERATIONS

SURGICAL HISTORY

ARE YOU SOCIAL ASSISTANCE? ☐ Yes ☐ No HEALTHCARE NUMBER: _____ EXPIRATION DATE: _____

DO YOU HAVE DENTAL COVERAGE? ☐ Yes ☐ No COMPANY: _____ POLICY #: _____ CERTIFICATE #: _____

X _____
DENTIST SIGNATURE

X _____
PATIENT SIGNATURE

_____
DATE

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