PLEASE PRINT

MEDICAL HISTORY

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PATIENT'S NAME:_____ DATE:_____
LAST FIRST MIDDLE

Who referred you to this office? _____ ☐ D.D.S. ☐ M.D. ☐ D.O. ☐ Friend ☐ Phone Book ☐ Insurance Book

Dentist's Name: _____ Phone # and/or City: _____

Physician's Name: _____ Phone # and/or City: _____

☐ YES Have you ever had an allergic reaction to a drug, medicine, latex, tape, metal, or other material?
☐ NO If YES, indicate name of drug or material and type of reaction experienced (rash, hives, swelling, etc.)

☐ YES Have you taken any prescription drugs or herbal remedies during the ***last six months***?
☐ NO If YES, please list ***all drugs and herbal remedies*** and ***circle those which have been taken in the last week.***

☐ YES Have you been under the care of a physician in the ***past year*** or have you been hospitalized in the last ***five years?***
☐ NO If YES, please indicate when and why:

☐ YES Have you ever taken the following drugs (circle): Cancer chemotherapy; Aredia (pamidronate); Zometa (zoledronic acid); Fosamax (alendronate); Actonel (risedronate); Boniva (ibandronate); Bonefos (clodronate); Didronel (etidronate); Ostac (clodronate); Skelid (tiludronate); other bisphosphonates?
☐ NO If YES, please indicate when and why:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please check Yes or No for each.

☐ YES ☐ NO Heart disease, MURMUR or rheumatic fever
☐ YES ☐ NO High blood pressure
☐ YES ☐ NO Asthma or lung disease
☐ YES ☐ NO Hepatitis, jaundice, liver disease
☐ YES ☐ NO Diabetes, kidney disease, or ulcers
☐ YES ☐ NO Prolonged bleeding
☐ YES ☐ NO Alcohol dependency or drug dependency
☐ YES ☐ NO Tobacco use
☐ YES ☐ NO Blood disease or cancer
☐ YES ☐ NO Major operation
☐ YES ☐ NO Artificial joints
☐ YES ☐ NO AIDS or exposure to AIDS or HIV
☐ YES ☐ NO Other serious illness
☐ YES ☐ NO Are you pregnant or breast-feeding?
☐ YES ☐ NO Are you taking oral contraceptives?

Your Height and Weight: _____ft. _____in. _____lbs.

FOR PATIENTS HAVING SURGERY TODAY:

☐ YES ☐ NO Do you have a cold or cough?
☐ YES ☐ NO Did you come to the office alone?
☐ YES ☐ NO Do you plan to drive home today?
☐ YES ☐ NO Have you had any food or fluid during the past 8 hours?

AFFIDAVIT AS TO THE TRUTH OF MY MEDICAL HISTORY

I have answered all the above questions and have indicated YES or NO in the proper places to the best of my knowledge. I certify that all the answers are truthful and understand that false or incorrect answers could jeopardize my care and my health.

DATE _____ SIGNATURE _____ RELATIONSHIP TO PATIENT (if patient is a minor) _____

If the patient is unable to read or understand these records and another person filled them out, the name of that person is:

DATE _____ SIGNATURE OF INTERPRETER/CAREGIVER _____ PRINTED NAME OF INTERPRETER/CAREGIVER _____

REVIEWED BY: _____ _____
RECEPTIONIST'S INITIALS DOCTOR