DATE:

PATIENT IS AN: ADULT ○ CHILD ○ ADULT UNDER GUARDIANSHIP ○ NAME OF GUARDIAN _____

Name:_____ Nickname: _____ Dr.○ Mrs.○ Ms.○ Mr.○

Home Address:_____

Home Phone: _____ Cellular Phone: _____ Fax#: _____

Date of Birth: Age:_____ Sex: _____ Marital Status: Single

Driver's License #: _____

Family Physician: _____ Phone: _____

Medical Specialist (if presently under care): _____ Phone: _____

OCCUPATION:_____

Employed By: _____ Phone: _____ Ext. _____

Spouse Employed By: _____ Phone: _____ Ext. _____

DENTAL INSURANCE: Yes○ No○ Group Policy #:_____ Certif. #:_____

Primary Insurance Co. Name: _____

Secondary Ins. Co. Name: _____

Group Policy #:_____ Certif. #:_____

PERSON RESPONSIBLE FOR ACCOUNT: Self ○ Other ○ Name: _____

Address: _____ Driver's License #: _____

Home Phone: _____ Business Phone: _____Ext. _____S.I.N.: _____

IN CASE OF EMERGENCY Please Notify: _____ Relationship: _____

Home Phone: _____ Business Phone: _____ Ext. _____

Is any other member of your family or relative a patient at our office? _____

REASON FOR TODAY'S VISIT: Examination ○ Emergency ○ Other ○ _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY PLEASE CHECK YES OR NO. IF NOT SURE, CHECK NS.	NO	NS	YES
Are you presently under a Doctor's care? Why?	○	○	○
Have you been under Doctor's care in the past two years? Why?	○	○	○
Have you taken any medication, pills or drugs in the past two years?	○	○	○
Are you presently taking medication, pills or drugs? If YES, please list them:	○	○	○
Have you ever had Tonsillitis?	○	○	○
Have you been hospitalised in the past two years? (If yes, why?)	○	○	○
Have you ever had any type of surgery? What & When?	○	○	○
When was your last complete physical examination?			
When walking, do you ever have to stop because of pain in your chest or shortness of breath?	○	○	○
Are you on a prescription diet?	○	○	○
Have you ever been diagnosed as having a tumor or cancer?	○	○	○
Have you ever taken cortisone/steroid medication?	○	○	○
Do you experience problems with healing?	○	○	○
Do you wish to speak privately with the Doctor about any problems?	○	○	○
Do you smoke? (If yes, how much?)	○	○	○
Are you currently in good health?	○	○	○
Do you bruise easily or bleed excessively?	○	○	○
Have you ever been warned about anaesthetic risks?	○	○	○
Do you drink alcohol? (If yes, how much?)	○	○	○

SHADED AREAS - OFFICE USE ONLY

MEDICAL ALERT	CONDITION	PRE MEDICATION	ALLERGIES	ANAEST

ALLERGIES **Please check off any medications you are allergic to or you have reacted adversely to:**

☐ Ibuprofen (Advil)	☐ Nembutal	☐ Demerol	☐ Ampicillin	☐ Rovamycin	☐ Local Anaesthetic (Freezing)
☐ Aspirin	☐ Seconal	☐ Percodan	☐ Erythromycin	☐ Cedhalexin	☐ Nitrous Oxide
☐ Tylenol	☐ Naproxen	☐ Darvon	☐ Clindamycin	☐ Sulpha Drugs	☐ Amoxicillin
☐ Tylenol #2, #3, # 4	☐ Toradol	☐ Penicillin	☐ Scopolamine	☐ Metal	☐ Chlorhexidene (Peridex)
☐ 222, 282, 292	☐ Codeine	☐ Valium	☐ Tetracycline	☐ Latex	☐ Bandage

☐ **Food Allergies, please list:**

Please list any other medication or substances which you know you are allergic to:

MEDICAL CONDITIONS **Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)**

	No	NS	Yes		No	NS	Yes		No	NS	Yes
Malignant Hyperthermia	○	○	○	Scarlet Fever	○	○	○	Rheumatic Fever	○	○	○
Stomach/Intestinal Problems	○	○	○	Kidney Trouble	○	○	○	Artificial Joints/Hips	○	○	○
Transdermal Nicotine Patches	○	○	○	Ulcers	○	○	○	Diabetes or Hypoglycemia	○	○	○
High Blood Pressure/Hypertension	○	○	○	Asthma	○	○	○	Arthritis/Rheumatism	○	○	○
Low Blood Pressure	○	○	○	Hay Fever	○	○	○	Epilepsy or Seizures	○	○	○
Heart Failure	○	○	○	Sinus Trouble	○	○	○	Glandular Disorders	○	○	○
Congenital Heart Lesion	○	○	○	Emphysema	○	○	○	Psychiatric Care	○	○	○
Artificial Heart Valve	○	○	○	Frequent Cough	○	○	○	Mental/Nervous Disorders	○	○	○
Heart Pacemaker	○	○	○	Lung Disease	○	○	○	AIDS (HIV Positive)	○	○	○
Heart Surgery	○	○	○	Bronchitis	○	○	○	Venereal disease	○	○	○
Heart Murmur	○	○	○	Tuberculosis	○	○	○	Herpes	○	○	○
Mitral Valve Prolapse	○	○	○	Liver Disease	○	○	○	Cold sores	○	○	○
Chest Pain	○	○	○	Hepatitis A (infec.)	○	○	○	Fever blisters	○	○	○
Angina Pectoris	○	○	○	Hepatitis B (serum)	○	○	○	Blood Disorders	○	○	○
Shortness of Breath	○	○	○	Hepatitis C	○	○	○	Circulation Problems	○	○	○
Stroke	○	○	○	Yellow Jaundice	○	○	○	Sickle Cell Anemia	○	○	○
Fainting or Dizziness	○	○	○	Thyroid Disease	○	○	○	Hemophilia	○	○	○
Anemia	○	○	○	Glaucoma	○	○	○	Cancer	○	○	○
Cardiac Arrest/Heart Attack	○	○	○	Pain in Jaw Joints	○	○	○	Chemotherapy/Radiation	○	○	○
Swelling of Feet/Ankles/Hands	○	○	○	Head/Neck Injuries	○	○	○	X-Ray/Cobalt Treatment	○	○	○
Drug or Alcohol Addiction	○	○	○	If Yes, have you received treatment?				Where?			

Is there anything else we have not mentioned that you think we should know regarding your medical history?

WOMEN ONLY	Are you pregnant?	Yes ○	No ○	Are you taking Fertility drugs?	Yes ○	No ○
	Are you nursing?	Yes ○	No ○	Are you taking Birth Control Pills?	Yes ○	No ○

Follow-up information to above questions: