MEDICAL HISTORY

Who is your Family Physician? _____ Phone:_____

Have you seen a physician for a medical condition in the last 6 months? ☐ No ☐ Yes **Date: _____**

Have you had an operation, illness, or been hospitalized in the last 5 years? ☐ No ☐ Yes **Reason? _____**

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment.

Please check the box for any condition you have now or had in the past.

(Parent/Guardian: please check the appropriate boxes concerning your child's health status.)

☐ Anemia	☐ Frequent Headaches	☐ Mental Disorders
☐ Asthma/Hay Fever	☐ Glaucoma	☐ Prolonged Bleeding
☐ Arthritis	☐ Heart Attack	☐ Prosthetic Joint Replacement
☐ Blood Disease	☐ Heart Murmur	☐ Radiation Treatment
☐ Blood Transfusion	☐ Heart Surgery	☐ Rheumatic Fever
☐ Cancer or Tumor	☐ Hepatitis/Jaundice	☐ Shortness of Breath
☐ Chest Pain	☐ High/Low Blood Pressure	☐ Sinus Trouble
☐ Diabetes	☐ HIV/AIDS (or another STI)	☐ Stroke
☐ Epilepsy/Seizures	☐ Kidney/Bladder Trouble	☐ Thyroid Disease
☐ Fainting	☐ Liver Disease	☐ Tuberculosis

Please list any Medical Conditions or concerns that are not mentioned about and the Doctor should be aware of:

_____

_____

PREFERRED PHARMACY

Name: _____ **Location:** _____

Phone #_____ **Fax #** _____

Please Check any medications you are currently taking or have taken:

☐ ***NONE***	☐ Anticoagulants	☐ Cortisone Drugs	☐ Steroids
	☐ Blood Thinners	☐ Sedatives	☐ Tranquilizers

Are you taking any other medication(s)? ☐ No ☐ Yes, Please Explain _____

Are you allergic to or suffer ill effects from any of the following?

☐ ***NO KNOWN***	☐ Aspirin	☐ Dental Anesthesia	☐ Penicillin
ALLERGIES	☐ Codeine	☐ Household Bleach	☐ Other _____

Women Only: Are you Pregnant? ☐ No ☐ Yes, How many months? _____

Are you presently taking any kind of medicine routinely? (Birth control pills, shots, implant, hormone therapy, etc.)

Please Explain: _____

ALL: To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change I will inform the Dentist at my next appointment

I have received the Notice of Privacy Practice and understand my healthcare information may be disclosed as outlined within that notice.

Signature: _____ **Date**: _____

Please Complete Front & Back Thank You.