CONFIDENTIAL MEDICAL HISTORY FORM

LAST NAME: _____ *FIRST NAME:* _____ *BIRTHDAY:* _____

Are you now or have you recently been under a physician's care? ☐ *Yes* ☐ *No*
If "Yes", please give reason: _____

Date of last physical exam: _____ *Physician* _____ *Phone* _____

Have you ever been a patient in a hospital or had any serious illness? ☐ *Yes* ☐ *No*
If "Yes", please explain: _____

Please check ALL of the following either "yes" or "no":

YES	NO		YES	NO		YES	NO	
☐	☐	*Mitral Valve Prolapse*	☐	☐	*Hepatitis or Jaundice*	☐	☐	*Prolonged Bleeding*
☐	☐	*Rheumatic fever*	☐	☐	*Liver Disease*	☐	☐	*Fainting Tendency*
☐	☐	*Heart Trouble*	☐	☐	*Cancer or Tumor*	☐	☐	*Epilepsy*
☐	☐	*Heart Murmur*	☐	☐	*Tuberculosis*	☐	☐	*Thyroid Disease*
☐	☐	*High/Low Blood Pressure*	☐	☐	*Diabetes*	☐	☐	*Glaucoma*
☐	☐	*Chest Pain*	☐	☐	*Kidney/Bladder Trouble*	☐	☐	*Radiation Treatment*
☐	☐	*Stroke*	☐	☐	*Anemia*	☐	☐	*Mental Disorders*
☐	☐	*Shortness of Breath*	☐	☐	*Lung Disease*	☐	☐	*HIV or AIDS*
☐	☐	*Asthma* or Hay Fever	☐	☐	*Venereal Disease*	☐	☐	*Prosthetic Joint Replacement*
☐	☐	*Sinus Trouble*	☐	☐	*Blood Disease*	☐	☐	*Blood Transfusion*
☐	☐	*Chemotherapy*	☐	☐	*Back Problems*	☐	☐	*Stomach/Intestinal Disease*
☐	☐	*Jaw Joint Problems*	☐	☐	*Arthritis*	☐	☐	*Rheumatic Fever*
☐	☐	*Artificial Heart Valves*	☐	☐	*Radiation Treatment*	☐	☐	*Tumors/Growths*
☐	☐	*Pacemaker*	☐	☐	*Scarlet Fever*	☐	☐	*Cold Sores/fever blisters*

Do you have any disease, condition, or problem not listed? Please list _____

Have you ever been told you should take antibiotic premedication before dental work? Yes/No What kind? _____

Do you Smoke or use tobacco products? Yes/No

Please check any of the following that you are taking or have taken:

☐ *Cortisone Drugs* ☐ *Anticoagulants* ☐ *Tranquilizers*
☐ *Steroids* ☐ *Blood Thinners* ☐ *Sedatives*
☐ *Phen-Fen* ☐ *Redux*

Are you taking any medication? ☐ *Yes* ☐ *No*
Please list name and dosage. Please include birth control, hormones & vitamins.

_____ _____
_____ _____
_____ _____

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

☐ *Penicillin* ☐ *Codeine* ☐ *Dental* Anesthesia
☐ *Aspirin* ☐ *Household Bleach* ☐ *Other:* _____
☐ *Latex (rubber)*

Women: Are you Pregnant? ☐ *Yes* ☐ *No* *If "Yes", how many months?* _____

I certify that I have read and understand the above information to the best of my knowledge. I have answered the questions accurately, and understand failure to do so could be dangerous to my health.

Signature: _____ **Relation to patient:** _____ **Date:** _____

(Please write any additional information on the back of this form – Thank You!)