HEALTH HISTORY

NAME ______ SINGLE ______ MARRIED ______ DIVORCED ______ SEPARATED ______ WIDOWED ______

NAME OF SPOUSE ______ HOME PHONE ______ PATIENT SOCIAL SECURITY NO. ______

RESIDENCE ADDRESS ______ CITY ______ STATE ______ ZIP ______

EMPLOYED BY ______ CITY ______ STATE ______ BUSINESS PHONE ______

PRESENT POSITION ______

SPOUSE EMPLOYED BY ______ PHONE ______

PRESENT POSITION ______ SPOUSE DOB ______

SPOUSE'S SOCIAL SECURITY NUMBER ______

REFERRED BY ______ ADDRESS ______

WHO WILL PAY FOR THIS ACCOUNT? ______

NAME OF YOUR DENTAL INSURANCE COMPANY ______

FORM [illegible] [illegible] ITEM [illegible]

MEDICAL HISTORY

PHYSICIAN'S NAME ______ Date of last physical exam ______

Patient Birthdate ______ Age ______

Do you have or have you had any of the following. Please indicate with a check mark (✓)

- ___ Any heart problems
- ___ High blood pressure
- ___ Low blood pressure
- ___ Circulatory problems
- ___ Nervous problems
- ___ Radiation treatments
- ___ Excessive bleeding
- ___ A Bad Reaction to "Novocaine"
- ___ AIDS/HIV
- ___ Allergies to anesthetics
- ___ Allergies to medicines or drugs
- ___ Allergies to ______
- ___ Anemia
- ___ Any Pain or Swollen Joints
- ___ Arthritis
- ___ Asthma
- ___ Cancer or a Tumor
- ___ Diabetes
- ___ Epilepsy (Fainting Spells, Seizures)
- ___ Frequent Headaches
- ___ Frequent Nose Bleeds
- ___ Growing Pains
- ___ Hepatitis
- ___ Kidney Disease
- ___ Liver Disease
- ___ Malignancies
- ___ Measles
- ___ Mumps
- ___ Psychiatric Care
- ___ Rheumatic Fever
- ___ Scarlet Fever
- ___ Shortness of Breath
- ___ Sinus Problems
- ___ Skin Disease (Hives or Skin Rash)
- ___ Stroke
- ___ Swelling of the Ankles
- ___ Thyroid Disease
- ___ Typhoid Fever
- ___ Tonsillitis
- ___ Tuberculosis
- ___ Ulcer
- ___ Unexplained Bruises
- ___ Venereal Disease

ARE YOU: ....

Taking any medicine? YES NO
Specify: ______

Being treated by a doctor (physician) now? YES NO

Are you pregnant? YES NO

Have you taken ACTH or cortisone in the past 12 months? YES NO

Gaining or losing weight? YES NO

Blood Pressure: S_____/D_____/_____

List any operations or major illnesses during the last 2 years ______

Have you reached Menopause? (change of life) YES NO