CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME _____ **BIRTHDATE** / / **SSN** _____

The following information is essential for this office to provide care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your health needs safely and efficiently. Incorrect information can be dangerous to your health.

Name of Medical Physician _____ Phone _____

Address _____

Date of Last Visit _____ Reason For Last Visit _____

Is your general health Good ❒ Fair ❒ Poor ❒

List any **Allergies** to drugs or medicine	List any **Medicine**, drugs you are taking	List any previous **Hospitalizations**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any conditions that you have had

Heart Condition	High Blood Pressure	Kidney Problems
Heart Murmur	Lung Disease	Bladder Infections
Mitral Valve Prolapse	Bronchitis	Diabetes
Rheumatic Fever	Emphysema	Thyroid Disorder
Artificial Heart Valve	Asthma	Sickle Cell Disease
Total Knee Replacement	TB	Anemia
Total Hip Replacement	Liver Problems	Transfusions
Arterial Grafts	Jaundice	Cancer
Other Implant Devices	Hepatitis	Venereal Disease
Heart Surgery	Ulcers	Glaucoma
_____	Stroke	Bleeding Disorder
_____	Nervous Disorders	Aids/HIV

Yes	No	
❒	❒	Do you have chest pain?
❒	❒	Do you have shortness of breath?
❒	❒	Do your ankles swell?
❒	❒	Do you smoke? How much? _____
❒	❒	Do you have a frequent cough?
❒	❒	Do you have difficulty breathing through your nose?
❒	❒	Have you ever had hives, weakness or difficulty breathing after an injection?
❒	❒	Have you had trouble with a general anesthetic?
❒	❒	Do you bruise easily?
❒	❒	Have you had prolonged bleeding following surgery?
❒	❒	Have you had radiation treatment for cancer?
❒	❒	Have you had chemotherapy?
❒	❒	Have you ever taken cortisone, prednisone or steroids?
❒	❒	Is there any unlisted health condition your Doctor should know?
❒	❒	Have you had anything to eat or drink in the past 6 hours?
❒	❒	Family history of anesthesia or bleeding complications?
❒	❒	Have you taken diet pills in last year? If yes, what kind? _____

Yes	No	
❒	❒	Are you allergic to eggs?
❒	❒	Are you on any drugs for osteoporosis or bone cancer?
□	□	**Do you currently use drugs for recreational use?**
□	□	**Have you ever had treatment for substance abuse?**
□	□	**Do you take a blood thinner or aspirin?**

WOMEN PATIENTS

Yes	No	
❒	❒	Are you pregnant now?
❒	❒	Do you anticipate becoming pregnant?
❒	❒	Are you breast feeding?

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Signature _____

Print Name: _____

If other than patient, indicate relationship: _____ Date _____ / _____ / _____