

PATIENT MEDICAL HISTORY INFORMATION

Date _____

Physician's Name _____ Address _____ Phone _____

Date of last medical exam _____ Nature of Exam _____

Describe you / your child's general health _____ Date of Birth _____ Age _____ Height _____ Weight _____

What is your anxiety level to being in a dental office: LOW MODERATE HIGH PLEASE CIRCLE ONE

- 1. Have you ever had a serious illness or operation? ... YES NO
Please explain
2. Are you currently under a doctor's care? Why? YES NO
3. Have you been hospitalized during past two years? Why? YES NO
4. Are you limited in activity because of a physical or medical condition? YES NO
5. Are you presently under excessive emotional, mental or occupational stress? YES NO
6. Are you currently taking any medications, pills, drugs, or syrups? YES NO
7. Do you bleed excessively when cut or have a tooth extracted? YES NO
8. Have you ever had any serious trouble associated with previous dental treatment or dental anesthetic? YES NO
9. Are you allergic to (please circle):

ANTIBIOTICS ASPIRIN CODEINE JEWELRY LATEX RUBBER METALS PAIN PILLS PENICILLIN

List any other allergies _____

10. Do you have or have you ever had any of the following:

- Abnormal Blood Pressure Congenital Heart Problem Hearing Aid Recreational Drugs
AIDS Diabetes Hepatitis A (Infectious) Recovering Alcohol / Drug Abuser
Anemia Epilepsy / Seizures Hepatitis B (Serum) Rheumatic Fever
Angina / Chest Pain Eyeglasses / Contacts HIV Positive Sexually Transmitted Disease
Arthritis Fainting Spells Kidney Trouble Sinus Trouble / Sinusitis
Artificial Hip / Joint / Limb Frequent Headaches Liver Trouble Stroke
Asthma Glaucoma Mitral Valve Prolapse Substance Addiction
Bacterial Endocarditis Heart Valve Replacement Nervousness Swelling of Ankles
Breathing Problems Heart Murmur Pacemaker Ulcers / Colitis
Cancer / Tumors Heart Trouble Psychiatric Care Other
Chemo-Therapy Heart Surgery Radiation Therapy NONE OF THE ABOVE

- 11. Do you exercise regularly? What activity? YES NO
12. Do you smoke or chew tobacco products? If yes, which products and how often? YES NO
13. Do you consume more than two alcoholic drinks per day? YES NO
14. Women: Do you take birth control pills? YES NO
Are you pregnant? (If maybe circle yes) Delivery date YES NO
Are you nursing? YES NO
15. Is there any other disease, condition, or problem you have that may effect the success of your dental treatment? YES NO
16. Would you like to speak to the doctor privately about any problem? YES NO

17. I the undersigned (patient or legally responsible party) certify that the information given on this form is true and correct, authorize dental diagnosis and treatment to be performed by Dr. Phillips and his associates / staff, and assume financial responsibility for dental services.

Signature _____ Date _____

ADULT PATIENT FATHER / HUSBAND MOTHER / WIFE GUARDIAN

FOR OFFICE USE ONLY

MEDICAL UPDATES: I have read my medical history dated _____ and confirm that it adequately states past and present conditions, with the following exceptions:

Table with 4 columns: EXCEPTIONS, SIGNATURE, DATE, OFFICE NOTES. Includes rows for 'NONE' entries.

OFFICE HEALTH SUMMARY: BP _____ PULSE _____ RESPIRATION _____

ASA _____ MED. ALERT _____
REVIEWED BY: DOCTOR _____ CLINICAL ASSISTANT _____ DATE _____