PATIENT MEDICAL HISTORY

Aloha

Patient#____________________________

Social Security#____________________

Date________________________________

PRIMARY CARE PHYSICIAN

PHYSICIAN____________________________ OFFICE PHONE______________________________ DATE OF LAST EXAM_______________________

ARE YOU CURRENTLY UNDER MEDICAL TREATMENT?____

ARE YOU CURRENTLY TAKING ANY MEDICATION (S) INCLUDING NON-PRESCRIPTION MEDICINE?__________________________

IF YOU ANSWERED YES, WHAT MEDICATIONS ARE YOU TAKING?____

WOMEN ONLY: ARE YOU PREGNANT?__________________ ARE YOU NURSING?_____________________ ARE YOU TAKING CONTRACEPTIVES?__________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

Condition			Condition			Condition			Condition		
1. HIGH BLOOD PRESSURE	YES	NO	9. LEUKEMIA	YES	NO	17. HEART MURMUR	YES	NO	25. ULCERS	YES	NO
2. HEART ATTACK	YES	NO	10. DIABETES	YES	NO	18. ANGINA	YES	NO	26. OSTEOPOROSIS	YES	NO
3. RHEUMATIC FEVER	YES	NO	11. KIDNEY DISEASE	YES	NO	19. FREQUENTLY TIRED	YES	NO	27. STROKE	YES	NO
4. SWOLLEN ANKLES	YES	NO	12. AIDS/HIV	YES	NO	20. EMPHYSEMA	YES	NO	28. HAY FEVER/ALLERGIES	YES	NO
5. FAINTING/SEIZURES	YES	NO	13. THYROID PROBLEM	YES	NO	21. CANCER	YES	NO	29. RADIATION THERAPY	YES	NO
6. ASTHMA	YES	NO	14. ACID REFULX	YES	NO	22. ARTHRITIS	YES	NO	30. LIVER DISEASE	YES	NO
7. LOW BLOOD PRESSURE	YES	NO	15. HEART DISEASE	YES	NO	23. JOINT REPLACEMENT	YES	NO	31. TUBERCULOSIS	YES	NO
8. EPILEPSY/CONVULSIONS	YES	NO	16. PACEMAKER	YES	NO	24. HEPATITIS/JAUNDICE	YES	NO	32. HEART TROUBLE	YES	NO

Question		
1. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS WITHIN THE LAST FIVE YEARS?	YES	NO
2. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	YES	NO
3. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISOPHONATES?	YES	NO
4. DO YOU USE TOBACCO?	YES	NO
5. DO YOU USE CONTROLLED SUBSTANCES?	YES	NO
6. ARE YOU WEARING CONTACT LENSES/	YES	NO
7. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS?	YES	NO

ALLERGIES

Allergy		
1. LOCAL ANESTHETICS	YES	NO
2. PENICILLIN/ANTIBIOTICS	YES	NO
3. SULFA DRUGS	YES	NO
4. BARBITURATES	YES	NO
5. IODINE	YES	NO
6. ASPRIN	YES	NO
7. ANY METALS	YES	NO
8. LATEX RUBBER	YES	NO
9. OTHER:_______________________		

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE KNOWLEDGE TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS TO THIRD PARTY PAYORS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X ____ DATE:______________________________