

Patient name _____ Birth date _____ MONTH DAY YEAR

How should we address you? _____

MEDICAL HISTORY

Who is your medical doctor? _____ Address _____

_____ M.D. Phone _____

Date of last health exam _____ Purpose _____

Have you ever been hospitalized? _____ If so, for what _____

Have you ever smoked? YES NO

Do you have any orthopedic implants or heart implants? _____

Please list all of the medications which you are presently taking and why? _____ (including aspirin)

Are you allergic to any medications? YES NO If so, please name. _____

Do you consume more than 2 alcoholic drinks per day? YES NO

May we request your health records if necessary YES NO

Are you pregnant? YES NO Expected due date _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Infected	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Unintentional Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Unintentional Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
						Other	<input type="checkbox"/>	<input type="checkbox"/>

COMMENT LINE _____

DENTAL HISTORY

Reason for todays visit? _____ Last dental visit _____

Purpose _____ Last complete exam _____

How would you describe your present oral condition? Good Fair Poor

Homecare: Brush _____ Floss _____

Do your gums bleed? Yes No

Do you have bad breath or taste? Yes No

Is keeping your natural teeth important to you? _____

Have you had any unusual effect from previous dental treatment? Yes No

Describe _____

Children and Adolescents: Does your child have a nick-name? _____

Has this child ever had an unfavorable experience in a dental office? Explain _____

_____ Does your child have a finger sucking habit? _____

AUTHORIZATION

I hereby authorize Anthony J. Tabone, D.D.S. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I attest the information on this form is correct to the best of my knowledge.

*Signature _____ Date _____

*If patient is under 18 years of age, parent must sign for patient.

I have read my medical history dated _____ and confirm that it adequately states past and present conditions.

DATE	SIGNATURE	B.P.	REVIEWED BY
_____	_____	_____	Dr. _____
_____	_____	_____	Dr. _____
_____	_____	_____	Dr. _____