Confidential Medical/Dental History Form

Name: (Last, First, Middle):_____
Address:_____
City, State, Zip:_____
Home Phone:_____**Work Phone:**_____
SSN:_____ **DOB**:_____ **Sex** : F/M
Please circle: Married Single Divorced
Email Address:_____ **Referred By:**_____

Physician:_____ **Office Phone**:_____
1. **Are you currently under a physician's care?** _____ Yes_____No
2. **Are you currently taking prescription medications?** _____ Yes_____No
   *If yes, what medications?_____

3. **Have you ever taken Fen-Phen/Redux?** _____ Yes_____No
4. **Do you use alcohol or drugs?** _____ Yes_____No
5. **Do you smoke or use tobacco?** _____ Yes_____No
6. **Are you allergic to or have you had reactions to the following?**Check all that apply

_____ Aspirin _____Codeine _____Penicillin _____Latex _____Metals
_____Anesthetic _____Barbiturates _____Other:_____

7. Do you or have you had problems with any of the following? Check all that apply

_____Abnormal Bleeding	_____Alcohol Abuse	_____Allergies
_____Anemia	_____Angina	_____Arthritis
_____Asthma	_____Blood Transfusion	_____Cancer/Chemo
_____Congenital Heart	_____Colitis	_____Diabetes
_____Dialysis	_____Difficult Breathing	_____Drug Abuse
_____Emphysema	_____Epilepsy	_____Glaucoma
_____Frequent Headaches	_____Heart Attack	_____Heart Surgery
_____Hemophilia	_____Hepatitis A,B, or C	_____HIV+/AIDS
_____High Blood Pressure	_____Joint Replacement	_____Kidney/Bladder
_____Low Blood Pressure	_____Leukemia	_____Liver Disease
_____Mitral Valve Prolapse	_____Mental Health	_____Pacemaker
_____Radiation Therapy	_____Rheumatic Fever	_____Seizures
_____Shingles	_____Sickle Cell Disease	_____Sinus Problems
_____Stroke	_____Tuberculosis	_____Ulcers
_____Heart Murmur	_____Other:_____	

8. Women Only: A.) Are you pregnant or breast-feeding? ____Yes ____No
*If yes, how many weeks pregnant? _____
B.) Are you taking (please circle): Birth Control Pills Hormone Therapy

Responsible Party for Patient: The above information is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. **Signature**:_____