MEDICAL HISTORY FORM **Date:** _____

Name: _____ **Home Phone:** ( ) _____

Address: _____ **Business Phone:** ( ) _____

City: _____ **State:** _____ **Zip Code:** _____ **Cell Phone:** ( ) _____

E-Mail: _____ **Occupation:** _____ **Date of Birth:** _____/_____/_____

Social Security No: _____ **Sex:** M F **Height:** _____ **Weight:** _____ **Single:** _____ **Married:** _____

Closest Relative: _____ **Relation:** _____ **Phone:** ( ) _____

If you are completing this for another person, what is your relationship to that person?
_____

Referred By: _____ **Phone:** ( ) _____

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during you initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Are you in good health?	YES	NO
Has there been any change in you general health within the past year?	YES	NO
My last physical examination was on		
Are you now under the care of a physician(s)?	YES	NO
If so, what is the condition(s) that is being treated?		
The name address and phone number of my physician(s):		
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	YES	NO
If so, what was the illness or problem?		
Are you taking any medicine(s) including non-prescription medicine(s)?	YES	NO
If so, what medicine(s) are you taking?		
Do you have or have you had any of the following diseases or problems? Please circle all that apply	YES	NO
Damaged heart valve(s), artificial heart valve(s), heart murmur, rheumatic heart disease		
Cardiovascular disease: heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion,		
High blood pressure, arteriosclerosis, stroke		
Do you have chest pain upon exertion?	YES	NO
Are you ever short of breath after mild exercise or when lying down?	YES	NO
Do your ankles swell?	YES	NO
Do you have inborn heart defects?	YES	NO
Do you have a cardiac pacemaker?	YES	NO
Allergy	YES	NO
Sinus Trouble	YES	NO
Asthma or Hay Fever	YES	NO
Fainting spells or seizures	YES	NO
Persistent diarrhea or recent weight loss	YES	NO
Diabetes	YES	NO
Hepatitis, Jaundice or Liver trouble	YES	NO

AIDS or HIV infection	YES	NO
Thyroid Problems	YES	NO
Respiratory problems, Emphysema, Bronchitis or any other not specified	YES	NO
Arthritis or Painful Swollen Joints	YES	NO
Stomach Ulcer or Hyperacidity	YES	NO
Kidney Trouble	YES	NO
Tuberculosis	YES	NO
Persistent cough or Cough that produces blood	YES	NO
Persistent swollen glands in neck	YES	NO

Low Blood Pressure	YES	NO
Sexually Transmitted Disease	YES	NO
Epilepsy or other neurological disease	YES	NO
Problems with mental health	YES	NO
Cancer	YES	NO
Problems of the Immune System	YES	NO
Have you had abnormal bleeding?	YES	NO
Have you ever required a blood transfusion?	YES	NO
Do you have any blood disorder?	YES	NO
Have you ever had any treatment for a tumor or growth?	YES	NO
Are you allergic or have you had a reaction to:		
Local Anesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Barbiturates, sedatives, or sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Codeine or other narcotics	YES	NO
Other not listed	YES	NO
Do you smoke?	YES	NO
What do you smoke?		
How much do you smoke and how often?		
Have you had any serious trouble associated with any previous dental treatment?	YES	NO
If so, explain		
Do you have any disease(s), condition(s), or problem(s) not listed above that you think I should know about?	YES	NO
If so, explain		
Are you wearing contacts?	YES	NO
Are you wearing removable dental appliances?	YES	NO
WOMEN		
Are you pregnant?	YES	NO
Do you have any problems associated with your menstrual cycle?	YES	NO
Are you nursing?	YES	NO
Are you taking birth control pills?	YES	NO

Chief Dental Complaint:

_____

_____

_____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I made in the completion of this form.

Signature of Patient: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning medical history:
_____
_____
_____

Significant findings from questionnaire or oral interview:
_____

_____-
_____
_____

Dental Management Considerations:
_____

Signature of Dentist: _____ Date: _____

Medical History Update: _____ Comments: _____ Signature: _____

Center for Implant and Family Dentistry of Astoria, PC

Acknowledgment of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations

ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

_____

_____**Signature of the Patient or Personal Representative**

Print Name of Patient or Personal Representative (including description of legal authority)

Date