

IDENTIFICATION DATA (Please print the following information)

Date _____ Age _____

Name _____ M ___ F ___ Date of Birth ____ \ ____ \ ____

Address _____ Marital Status: Married Separated Divorced
 Widowed Single

Res. Phone () _____

Bus. Phone () _____

FAMILY HISTORY – List Immediate family members who have died (Father, Mother, etc.):

Circle Illnesses immediate family members have had:

- | | | | |
|--------------|---------------------|--------------------|----------|
| Tuberculosis | Heart Disease | Hay Fever | Glaucoma |
| Diabetes | High Blood Pressure | Asthma | |
| Cancer | Allergies | Sickle Cell Anemia | |

PATIENT HISTORY Please check if your medical history includes:

Date of last dental exam: _____

REVIEWER NOTES

EYE, EAR, NOSE

- 1. Hay Fever _____
- 2. Ear Infection _____
- 3. Hearing Loss _____
- 4. Eye Problems _____

GASTROINTESTINAL

- 5. Stomach Pain _____
- 6. Ulcers _____
- 7. Change In bowel Habits _____
- 8. Rectal Bleeding _____
- 9. Jaundice(Hepatitis) _____

CARDIO-RESPIRATORY

- 10. Trouble Breathing _____
- 11. Cough (If chronic) _____
- 12. Asthma _____
- 13. High Blood Pressure _____
- 14. Rheumatic Fever _____
- 15. Heart Disease _____
- 16. Activity Limitation _____
- 17. EKG-Last Date _____
- 18. Chest X-Ray - Date _____

GENITO-URINARY

- 19. Difficulty starting stream _____
- 20. Night time urination _____
- 21. Kidney Disease _____
- 22. Urinary Infection _____

FOR WOMEN ONLY

- 43. Irregularity of Periods _____
- 44. Abnormal Flow _____
- 45. PID/Pelvic Pain _____
- 46. Breast Disease _____
- 47. Last Menstrual Period, Date: _____
- 48. Last Pelvic/Pap Smear Date: _____
- 49. Birth Control? If so, what type: _____
- 50. No. of Pregnancies: _____ No. of Births: _____

NEURO-MUSCULAR

- 23. Weakness _____
- 24. Numbness/Tingling _____
- 25. Muscle Pain _____
- 26. Seizures/Epilepsy _____
- 27. Paralysis _____
- 28. Migraine/Headaches _____

SKELETAL

- 29. Joint Pain or Swelling _____
- 30. Back Problems _____
- 31. Arthritis _____

ENDOCRINE

- 32. Diabetes _____
- 33. Thyroid Problems _____
- 34. Recent Wt. Gain/Loss(10#) _____

HEMATOLOGIC

- 35. Sickle Cell Disease _____
- 36. Anemia _____
- 37. Bleeding Tendencies _____
- 38. Thrombophlebitis/blood clots _____

OTHER (Additional space on back)

- 39. Cancer _____
 - 40. Mental/Emotional Problems _____
 - 41. V.D. History _____
 - 42. Tetanus Immunization _____
- Last Date: _____

Name _____

Date of Birth ____________

Patient History. Cont'd.

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

PLEASE INCLUDE ALL CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDS, HERBALS, PATCHES, INHALER, EYE DROPS & SUPPLEMENTS:

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

CURRENT LIFE STYLE:

Name your current occupation _____

	NO	YES
Do you use alcohol more than four times per week?	_____	_____
Do you smoke?	_____	_____
Do you ever use drugs recreationally?	_____	_____
Do you feel safe in your environment?	_____	_____

	YES	NO	Description
A) Eyes	_____	_____	
B) Ears, Nose, Throat	_____	_____	
C) Skin	_____	_____	
D) Nervous System	_____	_____	
E) Chest	_____	_____	
F) Heart	_____	_____	
G) Abdomen	_____	_____	
H) Genito-Urinary System	_____	_____	
I) Pelvic	_____	_____	
J) Extremities	_____	_____	
K) Back	_____	_____	
L) Pain – Location	_____	_____	

Pain Scale 0 1 2 3 4 5 6 7 8 9 10