Confidential Patient Information -II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____

Updated: _____

Updated: _____

Updated: _____

Updated: _____

HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

[YES]	[NO]	
❑	❑	1. Have you been hospitalized within the past 2 years? For what? _____
❑	❑	2. Are you currently being treated by a physician? For what? _____
❑	❑	3. Are you currently taking any medicines or drugs? What? _____
❑	❑	4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
❑	❑	5. Are you allergic to any drugs? What? _____ _____
❑	❑	6. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____
❑	❑	7. Are you allergic to any metals? What? _____ _____
❑	❑	8. Do you bleed excessively upon injury?
❑	❑	9. Are you pregnant?
❑	❑	10. Have you ever been involved with dental/medical legal activity?

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

A. AIDS	H. Heart Murmur	0. Nervous Breakdown
B. Arthritis	I. Heart Problem*	P. Rheumatic Fever
C. Asthma	J. Hepatitis	Q. Sexually Transmitted Diseases
D. Cancer	K. High Blood Pressure	R. Stroke
E. Diabetes	L. Jaundice	S. Tuberculosisor Psychiatric Therapy
F. Epilepsy	I. Kidney Problems	
G. Glaucoma	N. Low Blood Pressure	T. Other Diseases*

*If you circled either I or T, describe condition: _____

_____

_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN RELATIVE)

Name: _____

Address: _____

Telephone (Home) _____ (Work) _____

SIGNATURE: _____ REVIEW BY: _____

DATE: _____