CONFIDENTIAL MEDICAL HISTORY FORM

TJ SCHOEN FAMILY DENTISTRY
257 MAIN ST. W., PO BOX 128
WABASHA, MN 55981
651-565-4647

PATIENT NAME:

Date of Birth:

Physician:

Allergies to medication, substances, food, latex? Please list.

Current medications, vitamins and herbs (including OTC):

Are you Pregnant?	YES NO	Use Birth Control?	YES NO
Are you taking any medication for Osteoporosis? Please List			
Currently under Physician's Care? If so Why? Hospitalized in last two years? Why?			
Have you ever had or do you currently have any of the following? Please circle			
AIDS or HIV Positive	YES NO	Hay Fever/Sinus trouble	YES NO
Anemia	YES NO	Heart Murmur/pacemaker/heart trouble/ surgery	YES NO
Arthritis/Gout	YES NO	Human Papillomavirus (HPV)	YES NO
Artificial heart valve/ Artificial joints	YES NO	Glaucoma	YES NO
Asthma	YES NO	Hemophilia	YES NO
Autoimmune disorder	YES NO	Hepatitis A or B	YES NO
Blood disease/ Blood transfusion	YES NO	Herpes	YES NO
Cancer/Chemotherapy	YES NO	High Blood Pressure	YES NO
Cardiovascular Disease	YES NO	Hypoglycemia	YES NO
Chest Pain	YES NO	Kidney trouble	YES NO
Chemical dependency	YES NO	Liver or Lung disease	YES NO
Cold sores/Fever blisters	YES NO	Radiation therapy	YES NO
Congenital heart problems	YES NO	Rheumatic fever/Rhematism	YES NO
Cortisone treatment	YES NO	Psychiatric Care	YES NO
Diabetes	YES NO	Scarlet fever	YES NO
Emphysema/Shortness of breath	YES NO	Swelling feet/ankles/hand	YES NO
Epilepsy, Seizures, or Stroke	YES NO	Thyroid disease	YES NO
Excessive bleeding	YES NO	Tuberculosis	YES NO
Excessive thirst	YES NO	Ulcers	YES NO
Extreme nervousness	YES NO	Used Redux or Phen-phen	YES NO
Fainting or dizziness	YES NO	Yellow Jaundice	YES NO
Frequent cough	YES NO		

Please describe any current medical treatment including drugs, pending surgery or recent injuries or any other information we should be aware of that we haven't yet discussed.

I hereby certify that the above information is correct. *If there are any changes in my medical history, I will notify my dentist.* My scanned signature is a legal and binding agreement.

Date:

Signature:

Printed Name:
(Responsible party for the patient)