C. Roger Macias, Jr. DDS
Aesthetic and Restorative Dentistry

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM (please print firmly and clearly)

Name (Last, First, Middle) _____ Title _____

Address _____

Preferred Name _____ SSN _____ DOB _____ / _____ /_____

Home Phone (___) _____ Marital: _____ Ref. Doctor_____

Work Phone (___) _____ Sex: _____ Ref. Patient_____

Email _____

Medical Alerts_____

_____

Date of Last Physical Exam: _____ / _____ / _____

Are you now or have you recently been under a physician's care? ___ Yes ___ No

Reason _____

Have you ever been a patient in a hospital or had any serious illness?

Explain _____

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED:

❑ Yes ❑ No	Arthritis	❑ Yes ❑ No	Hepatitis or Jaundice	❑ Yes ❑ No	Prolonged Bleeding
❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Fainting Tendency
❑ Yes ❑ No	Heart Trouble	❑ Yes ❑ No	Cancer or Tumor	❑ Yes ❑ No	Epilepsy
❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Thyroid Disease
❑ Yes ❑ No	High/Low Blood Pressure	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Glaucoma
❑ Yes ❑ No	Chest Pain	❑ Yes ❑ No	Kidney/Bladder Trouble	❑ Yes ❑ No	Radiation Treatment
❑ Yes ❑ No	Stroke	❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Mental Disorders
❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	HIV or AIDS
❑ Yes ❑ No	Asthma or Hay Fever	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No	Prosthetic Joint Replacement
❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No	Blood Disease	❑ Yes ❑ No	Blood Transfusion

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CHECK ANY OF THE FOLLOWING THAT YOU ARE TAKING OR HAVE TAKEN:

❑ Yes ❑ No	Cortisone Drugs	❑ Yes ❑ No	Anticoagulants	❑ Yes ❑ No	Tranquilizers
❑ Yes ❑ No	Steroids	❑ Yes ❑ No	Blood Thinners	❑ Yes ❑ No	Sedatives

Are you taking any other medication? ___Yes ____No If yes, explain_____

ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING:

❑ Yes ❑ No	Penicillin	❑ Yes ❑ No	Codeine	❑ Yes ❑ No	Dental Anesthesia
❑ Yes ❑ No	Aspirin	❑ Yes ❑ No	Household Bleach	❑ Yes ❑ No	Other: _____

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WOMEN ONLY

Are you pregnant? ___Yes _____No If yes: How many months? _____ Are you breast feeding? _____

Are you presently taking medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy, etc:)

Explain_____

RESPONSIBLE PARTY FOR PATIENT

The above information is true to the best of my knowledge.

Name and Address _____

Signature _____

Please write any additional information on the back of this form—Thank you!

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