MEDICAL HISTORY

LAST NAME _____ FIRST _____

E-MAIL _____ CELL PHONE _____

STREET ADDRESS _____ P.O. BOX _____

CITY/STATE/ZIP _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S D.O.B. _____

SPOUSE'S SOCIAL SECURITY NUMBER _____

PHYSICIAN'S NAME _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S PHONE _____ DATE OF LAST PHYSICAL _____

IF PATIENT IS A MINOR, NAME OF PARENT OR GUARDIAN _____

PARENT OR GUARDIAN'S ADDRESS _____

PARENT OR GUARDIAN'S PHONE _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY? _____

ADDRESS _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

ADDRESS _____ PHONE _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

ADDRESS _____ PHONE _____

I WILL BE PAYING TODAY BY: CASH ____ CHECK ____ CREDIT CARD ____

List below the medications you currently take:

MEDICATION	USE	DOSE (mg)	TIMES PER DAY

Circle any of the following which you have had or have at the present:

Heart Failure	Wear Contact Lenses	Take Fen-Phen (Redux)
Heart Disease or Attack	Stroke	HIV Positive
Angina Pectoris	Anemia	AIDS
High Blood Pressure	Low Blood Pressure	Alcoholism
Heart Murmur	Hemophilia (Excessive Bleeding)	Liver Disease
Rheumatic Fever	Bruise Easily	Yellow Jaundice
Congenital Heart Lesions	Blood Transfusion	Thyroid Disease
Scarlet Fever	Artificial Joint	Kidney Trouble
Artificial Heart Valve	Asthma	Cortisone Medication
Mitral Valve Prolapse	Hayfever	Glaucoma
Heart Pacemaker	Sinus Trouble	Diabetes
Heart Surgery	Smoking	Cancer or Tumor
Allergies or Hives	Tuberculosis (TB)	Chemotherapy
Arthritis (Rheumatism)	Persistant Cough	Venereal Disease
X-Ray or Cobalt Treatment	Emphysema	Cold Sores
Hepatitis A (Infectious)	Jaw Joint Pain	Genital Herpes
Hepatitis B (Serum)	Nervousness	Sickle Cell Disease
Hepatitis C	Ulcers	Epilepsy or Seizures
Fainting or Dizzy Spells	Drug Addiction	Special Diet
Psychiatric Treatment	Drink Alcohol	Latex Allergy

Do you have any disease, condition or problem not listed? YES NO
if so, name of condition _____

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? YES NO
if so, name of medication _____

Women: Are you pregnant? YES NO
Are you breast feeding? YES NO
Are you taking birth control pills? YES NO

I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. If I ever have any change in my health, if my medicines change, or if the above information changes in any way, I will inform Dr. Custer at the next appointment without fail.
I authorize release of any information relating to insurance claims I may have and I authorize payment directly to Dr. Custer of the group insurance benefits otherwise payable to me.
Unless I otherwise request, I authorize Dr. Custer or his staff to perform an oral cancer screening and to examine, x-ray, restore, and apply fluoride to my teeth as they deem necessary. I understand that there are additional costs for these procedures beyond the fee charged for a routine cleaning.

DATE _____ SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____