DR. Alice CHARLAND BASSFORD
ASE DENTAL

MEDICAL-DENTAL HISTORY

NAME (Last, First, Middle): _____ TITLE: _____

ADDRESS: _____

REFFERRED NAME: _____ SS NO: _____ DOB: _____

HOME PHONE: _____ MARITAL: **SELECT** REF. DOCTOR: _____

WORK PHONE: _____ SEX: **SELECT** 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		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Hepatitis or Jaundice	☐	☐	Prolonged Bleeding
☐	☐	Rheumatic Fever	☐	☐	Liver Disease	☐	☐	Fainting Tendency
☐	☐	Heart Trouble	☐	☐	Cancer or Tumour	☐	☐	Epilepsy
☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐	Thyroid Disease
☐	☐	High/Low Blood Pressure	☐	☐	Diabetes	☐	☐	Glaucoma
☐	☐	Chest pain	☐	☐	Kidney/Bladder Trouble	☐	☐	Radiation Treatment
☐	☐	Stroke	☐	☐	Anemia	☐	☐	Mental Disorders
☐	☐	Shortness of Breath	☐	☐	Lung Disease	☐	☐	HIV or AIDS
☐	☐	Asthma or Hay Fever	☐	☐	Venereal Disease	☐	☐	Prosthetic Joint Replacement
☐	☐	Sinus Trouble	☐	☐	Blood Disease	☐	☐	Blood Transfusion

Check any of the following that you are taking or have taken:

YES	NO		YES	NO		YES	NO	
☐	☐	Antibiotic	☐	☐	Blood Pressure	☐	☐	Inhaler
☐	☐	Steroids	☐	☐	Blood Thinners	☐	☐	Artificial Joint

Are you taking any other medication? ☐ YES ☐ NO If yes, list: _____

Are you allergic to or do you suffer ill effects from any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Penicillin	☐	☐	Latex	☐	☐	Dental Anesthesia
☐	☐	Aspirin	☐	☐	Iodine	☐	☐	Other: _____

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: _____

The above information is true to the best of my knowledge.
RESPONSIBLE PARTY FOR PATIENT:
Name and Address: _____
Signature (Full Name and Date): _____

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