

PERSONAL INFORMATION - HEALTH HISTORY

James A. Merriman D.M.D., P.C.

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NAME _____ Birth date _____
Last First MI (Preferred name)

ADDRESS _____
Street City State Zip Code

Social Security No. _____ Preferred Appointment Times/Days _____

PHONE: (home) _____ (work) _____ (cell) _____

Email _____ Best number to contact you _____

Employer Name _____ Occupation _____

Whom may we thank for referring you to our office? _____

Spouse or Responsible Party Information (if someone other than yourself)

NAME _____ Employer _____

Birth date _____ **Social Security No.** _____ **Best number to contact** _____

ADDRESS _____
Street City State Zip Code

HEALTH HISTORY (please check if you have or had any of the following)

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you in good health? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding problems, bruise easily |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches, ringing in ears |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint pain or stiffness, arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart disease, murmurs, rheumatic fever, mitral valve prolapse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Premed _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joint Replacement |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Premed _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or liver disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Acid Reflux |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation treatment/Chemotherapy |

- | | |
|--|-------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression/Anxiety |
| | Meds: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney or bladder disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease, herpes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV positive, AIDS |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Allergy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold sores/ Fever Blisters |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | TB, emphysema or lung disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Tobacco Products |
| | Usage _____ |

List ANY and ALL ALLERGIES _____

List ANY and ALL DRUGS/MEDICATIONS you are currently taking _____

List ANY SURGERIES within the past 5 years _____