DR. MARK TERRY
1501 HAMBURG TPKE. STE. 304
WAYNE, N.J. 07470
973-694-2000

MEDICAL HISTORY

In order for us to best treat your conditions as efficiently as possible, would you please take a few minutes to answer the following questions. **Please** fill in **BOTH** sides completely.

PLEASE PRINT

NAME DR. / MR. / MRS. / MISS ______________________________ DATE ______________________

PAGER/CELL PHONE # ______________________________

EMERGENCY CONTACT (Name & Number) ______________________________

PHYSICIAN ______________________ PHONE NUMBER ______________________

PHYSICIAN'S ADDRESS ______________________________

PHARMACY ______________________ PHONE NUMBER ______________________

Circle a definite answer for each question:

Yes No Any change in your health in the last two years?
Yes No Are you currently under the care of a physician?
If yes, for what disorder? ______________________________

Yes No Have you had any medical treatment of any kind in the last two years? If yes, describe ______________________

Yes No Have you ever had any surgical operation of any kind? If yes, what type ______________________

Yes No Were you transfused at any time?
Yes No Have you been advised by a physician of the need for any type of surgery or treatment?
For what? ______________________________

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR ANY OF THE FOLLOWING?:

Yes	No	HEART PROBLEMS	Yes	No	EPILEPSY, SEIZURES
Yes	No	RHEUMATIC FEVER	Yes	No	ULCERS
Yes	No	HEART MURMUR	Yes	No	STOMACH OR INTESTINAL DISORDER
Yes	No	MITRAL VALVE PROLAPSE	Yes	No	TUMORS OR CANCER
Yes	No	HIP OR JOINT REPLACEMENT	Yes	No	RADIATION OR CHEMOTHERAPY
Yes	No	CONGENITAL HEART DEFECTS	Yes	No	HORMONE IMBALANCE
Yes	No	CIRCULATION PROBLEMS	Yes	No	KIDNEY DISORDER
Yes	No	PACEMAKER	Yes	No	ALLERGY TO WHAT?
Yes	No	STROKE	Yes	No	CHRONIC SINUS
Yes	No	HIGH BLOOD PRESSURE	Yes	No	ASTHMA OR HAY FEVER
Yes	No	LOW BLOOD PRESSURE	Yes	No	TUBERCULOSIS
Yes	No	HEPATITIS	Yes	No	FREQUENT HEADACHES
Yes	No	DIABETES	Yes	No	ARTHRITIS
Yes	No	ANEMIA	Yes	No	BACK PROBLEMS

(Over)

Yes	No	HEMOPHILIA, BLEEDING OR BLOOD DISORDER	Yes	No	COLD SORES (HERPES I)
			Yes	No	VENERAL DISEASE, HERPES II
Yes	No	HIV (AIDS)	Yes	No	ALCOHOL OR CHEMICAL DEPENDENCY
Yes	No	THYROID CONDITION	Yes	No	ANOREXIA, BULIMIA
Yes	No	FAINTING SPELLS	Yes	No	FOSAMAX OR AN EQUIVILANT

Yes No Are you sensitive to local anesthetics (Novacaine)?

Yes No Do you have medication allergies or been told not to take any medication? If yes, describe (e.g. Penicillin, Codeine, Sulfamycins) ______________________________

____

Yes No Are you currently taking any prescription drugs of any kind?
(Example: Birth Control, Blood Pressure, Diet)? If yes, what?: ______________________________

____

Yes No Are you currently taking any nonprescription drugs of any kind?
(Example: Aspirin, Cough Syrup, Nasal Spray)
If yes, what? ______________________________

____

Yes No Are you pregnant? Anticipated delivery date ______________________________

Yes No Do you use any tobacco product? Daily intake ______________________________

Yes No Do you wear contact lenses?

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE ______________________________ DATE ______________
Patient or Guardian of Minor

PERSONAL DATA
(Please complete)

CHIEF COMPLAINT (Problem) ______________________________

HOME ADDRESS ______________________________

HOME PHONE # ______________ SOCIAL SECURITY # ______________

DATE OF BIRTH ______________ SPOUSE'S NAME ______________

EMPLOYER ______________________________

POSITION ______________________________

BUSINESS ADDRESS ______________________________

BUSINESS PHONE # ______________________________

REFERRED BY (If other than your Dentist) ______________________________

GENERAL DENTIST'S NAME ______________________________

ADDRESS (If Known) ______________________________

PHONE # (If Known) ______________________________

DENTAL INSURANCE CO. ______________________________

MEDICAL INSURANCE CO. ______________________________