Dr. Gokhale

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Last Name_____ First Name_____ Date _____

Address:_____ Zip_____

Home ( )_____ Work ( )_____ Cell ( )_____

Email address_____

What is the best way to contact you?_____ May we text message you?_____

DOB:_____ SS# _____

Other Family Members that are patients _____

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

MEDICAL HISTORY

Are you now or have you recently been under a physician's care? ____yes _____no

Reason_____

Physician Name _____ Phone # _____

Please check any of the following medical conditions you may have had:

_____Arthritis
_____Hepatitis or Jaundice
_____Prolonged bleeding
_____Rheumatic Fever
_____Liver Disease
_____Fainting tendency
_____Heart trouble
_____Cancer or Tumor
_____Epilepsy
_____Heart Murmur or MVP
_____Recent hospitalization

_____Tuberculosis
_____Thyroid Disease
_____High/Low blood pressure
_____Diabetes
_____Glaucoma
_____Chest Pain
_____Kidney/bladder trouble
_____Radiation treatment
_____Stroke
_____Anemia
_____Prosthetic Heart Value

_____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

Current Medications? _____

_____

Allergies? _____

Tobacco in any form ?____Yes ___ No Recreational drugs _____

Are you pregnant? ____Yes ____No How far along?___ Breast feeding? ___

Yes, you may use my testimonial, photos, video and name to let other patients about my great experience with your office or for educational purposes.

Patient signature:_____ Date : _____

By signing here, I am verifying that all information on this form is accurate and current.