WILLIAM FRED MILTON D.M.D., D.PSc

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PLEASE PRINT

PERSONAL INFORMATION

NAME_____ DATE_____

ADDRESS_____CITY_____ STATE_____ZIP_____

PHONE_____ DATE OF BIRTH_____

MARITAL STATUS_____SEX_____AGE_____NUMBER OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

NAME OF SPOUSE_____ SPOUSE'S OCCUPATION_____

EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

CELL PHONE _____

EMAIL _____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

REFERRED BY_____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash , check or credit basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.
Date_____ Patient's Signature_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN?_____

_____

TODAYS CONDITION STARTED WHEN?_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

MEDICATIONS:_____

DRUG ALLERGIES:_____

Medical History

□ Ringing in Ear
□ Ear Infections – Frequent
□ Dizziness/Fainting
□ Failing Vision
□ Eye Infections
□ Nose Bleeds
□ Sinus Trouble
□ Sore Throats – Frequent
□ Hayfever/Allergies
□ Pneumonia
□ Bronchitis/Chronic Cough
□ Asthma/Wheezing
□ Chest Pain
□ High Blood Pressure
□ Heart Murmur
□ Swollen Ankles
□ Leg Pain • Walking
□ Varicose Veins/Phlebitis
□ Loss of Appetite
□ Difficulty Swallowing
□ Indigestion or Heartburn
□ Persistent Nausea/Vomiting
□ Peptic Ulcers
□ Abdominal Pain • Chronic

□ Gall Bladder Trouble
□ Jaundice/Hepatitis
□ Change in Bowel Habits
□ Diarrhea □ Constipation
□ Diverticulosis □ Crones's
□ Bloody or Tarry Stools
□ Hemorrhoids
□ Hernia
□ Urine infections – Frequent
□ Blood in Urine
□ Urination □ Overnight > Twice
□ Painful □ Loss of Control
□ Decrease in Force/Flow
□ Kidney Stones
□ Venereal Disease
□ Urethal Discharge
□ Chronic Fatique
□ Weight Loss • Recent
□ Anemia □ Bruise Easily
□ Cancer
□ Diabetes
□ Thyroid Disease
□ Convulsions/Seizures
□ Stroke

□ Tremors/Hands Shanking
□ Muscle Weakness
□ Numbness/Tingling Sensations
□ Headaches – Frequent
□ Arthritis/Rheumatism
□ Osteoporosis
□ Back Pain – Recently
□ Bone Fracture/Joint Injury
□ Gout
□ Foot Pain □ Cold Hands Feet
□ Rashes □ Hives
□ Psoriasis □ Eczema
□ Nervousness □ Depression
□ Memory Loss
□ Moodiness □ Excessive
□ Phobias
□ Mental Illness
□ Lactose Intolerance
□ Prostate Disease
□ Sexual/Menstrual Dysfunction
□ Frequent Infections
□ Dementia
□ Tetanus
□ Chicken Pox □ Polio □ Mumps

□ Measles □ Rubella □ Herpes
□ Rheumatic Fever
☐ Scarlet Fever ☐ Tuberculosis
□ Other_____
□ Other _____

Females – Please complete

□ Pregnant? □ Yes □ No

Menstrual Flow:

□ Regular □ Irregular

□ Pain/Cramps
___ Days of Flow ___
Length of Cycle ___

Date 1st day of last period _____

□ Pain/Bleeding during or after Sex

Number of:
____Pregnancies ___Abortions
____Miscarriages ___Live Births

Birth Control Method_____

□ BC Pill (Name)_____

□ Flushing/Menopause

□ Date of Last PAP Test_____

□ Normal □ Abnormal

□ Date of Last Mammogram

□ Normal □ Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

If more space is needed, please use blank area of the third page.

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE	_____
	_____	_____	_____	GLAUCOMA	_____
	_____	_____	_____	EPILEPSY	_____
SPOUSE				RHEUMATOID ARTHRITIS	
CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD PRESSURE	_____
				HEART DISEASE	
				BACK PROBLEMS	

Please list below the five main physical complaints you have in order of their importance.

1
2
3
4
5