

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

--	--	--	--

City State Zip:

Email:

--	--

Home Phone:

Work Phone:

Birth Date:

Social Security No.:

Marital Status:

--	--	--	--	--

Primary Dental Guarantor:

Home Phone:

Work Phone:

--	--	--

Secondary Dental Guarantor:

Home Phone:

Work Phone:

--	--	--

Physician Name:

Physician Phone:

--	--

Pharmacy:

Pharmacy Phone:

--	--

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ Are you pregnant?

If Yes, # of weeks

☐ ☐ Are you nursing?

Please answer the following:

Y N

☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only

BP

Heart Rate:

Weight:

Y N Conditions

- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Alcohol Abuse
- ☐ ☐ Allergies
- ☐ ☐ Anemia
- ☐ ☐ Angina Pectoris
- ☐ ☐ Arthritis
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Artificial Joints
- ☐ ☐ Asthma
- ☐ ☐ Blood Transfusion
- ☐ ☐ Cancer- Chemotherapy
- ☐ ☐ Colitis
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Cosmetic Surgery
- ☐ ☐ Diabetes
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Drug Abuse
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy
- ☐ ☐ Fainting Spells
- ☐ ☐ Fever Blisters
- ☐ ☐ Frequent Headaches

Y N Conditions

- ☐ ☐ Glaucoma
- ☐ ☐ HIV+ AIDS
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Surgery
- ☐ ☐ Hemophilia
- ☐ ☐ Hepatitis A
- ☐ ☐ Hepatitis B
- ☐ ☐ Hepatitis C
- ☐ ☐ High Blood Pressure
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Pace Maker
- ☐ ☐ Pneumocystitis
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Radiation Therapy
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Seizures
- ☐ ☐ Shingles
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Sinus Problems

Y N Conditions

- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease
- ☐ ☐ Yellow Jaundice

Y N Allergies

- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Dental Anesthetics
- ☐ ☐ Erythromycin
- ☐ ☐ Jewelry
- ☐ ☐ Latex
- ☐ ☐ Metals
- ☐ ☐ Penicillin
- ☐ ☐ Tetracycline

Other

Medications:

--	--	--

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____
(If Under 18, Parent or Guardian Signature Required)