

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

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City State Zip:

Email:

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Home Phone:

Work Phone:

Birth Date:

Social Security No.:

Marital Status:

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Primary Dental Guarantor:

Home Phone:

Work Phone:

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Secondary Dental Guarantor:

Home Phone:

Work Phone:

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Physician Name:

Physician Phone:

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Pharmacy:

Pharmacy Phone:

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For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Please answer the following:

	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks <input style="width: 30px;" type="text"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Are you nursing?</p>
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<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?</p>	<p>Height: <input style="width: 50px;" type="text"/></p>
For Office Use Only	
<p>BP <input style="width: 40px;" type="text"/></p>	<p>Heart Rate: <input style="width: 40px;" type="text"/></p> <p>Weight: <input style="width: 50px;" type="text"/></p>

<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50px;">Y N</th> <th style="text-align: left;"><u>Conditions</u></th> </tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Artificial Joints</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Cancer- Chemotherapy</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Cosmetic Surgery</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Difficulty Breathing</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Drug Abuse</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Emphysema</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Fainting Spells</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Fever Blisters</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Frequent Headaches</td></tr> </table>	Y N	<u>Conditions</u>	<input type="checkbox"/> <input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/>	Allergies	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/>	Artificial Joints	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/>	Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>	Colitis	<input type="checkbox"/> <input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/>	Drug Abuse	<input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	Fainting Spells	<input type="checkbox"/> <input type="checkbox"/>	Fever Blisters	<input type="checkbox"/> <input type="checkbox"/>	Frequent Headaches	<table style="width: 100%; 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Medications:

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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...

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Notes:

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Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)