

# 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		
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	If Yes, # of weeks <input style="width: 30px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	

Please answer the following:

Y	N		
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?	Height: <input style="width: 50px;" type="text"/>
<b>For Office Use Only</b>		BP <input style="width: 40px;" type="text"/>	Heart Rate: <input style="width: 40px;" type="text"/>
		Weight: <input style="width: 50px;" type="text"/>	

<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Y</th> <th style="text-align: left;">N</th> <th style="text-align: left;"><u>Conditions</u></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Bones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer- Chemotherapy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cosmetic Surgery</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficulty Breathing</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Drug Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emphysema</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting Spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fever Blisters</td></tr> <tr><td><input type="checkbox"/></td><td><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 Bones	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<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 border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Y</th> <th style="text-align: left;">N</th> <th style="text-align: left;"><u>Conditions</u></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Glaucoma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hay Fever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Attack</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Surgery</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hemophilia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis A</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis B</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HIV+ AIDS</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Liver Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mitral Valve Prolapse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pace Maker</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pneumocystitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Psychiatric Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Radiation Therapy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rheumatic Fever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizures</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shingles</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle Cell Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sinus Problems</td></tr> </table>	Y	N	<u>Conditions</u>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Y</th> <th style="text-align: left;">N</th> <th style="text-align: left;"><u>Conditions</u></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Thyroid Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tuberculosis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ulcers</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Venereal Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Yellow Jaundice</td></tr> </table> <div style="border: 2px solid black; padding: 5px; margin-top: 10px;"> <table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Y</th> <th style="text-align: left;">N</th> <th style="text-align: left;"><u>Allergies</u></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Aspirin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Codeine</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dental Anesthetics</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Erythromycin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jewelry</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Latex</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Metals</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Penicillin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tetracycline</td></tr> <tr><td colspan="3"><b>Other</b></td></tr> <tr><td colspan="3">_____</td></tr> <tr><td colspan="3">_____</td></tr> <tr><td colspan="3">_____</td></tr> </table> </div>	Y	N	<u>Conditions</u>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	Y	N	<u>Allergies</u>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<b>Other</b>			_____			_____			_____		
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 Bones																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve																																																																																																																																																																																																									
<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																																																																																																																																																																																																									
Y	N	<u>Conditions</u>																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																																																																																																																																																																																																									
Y	N	<u>Conditions</u>																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Stroke																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice																																																																																																																																																																																																									
Y	N	<u>Allergies</u>																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Codeine																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Latex																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Metals																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline																																																																																																																																																																																																									
<b>Other</b>																																																																																																																																																																																																											
_____																																																																																																																																																																																																											
_____																																																																																																																																																																																																											
_____																																																																																																																																																																																																											

**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)