

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: Cell Phone: Birth Date: Social Security No.: Marital Status:

Primary Dental Guarantor: Home Phone: Work Phone: Cell Phone:

Secondary Dental Guarantor: Home Phone: Work Phone: Cell Phone:

Physician Name: Physician Phone:

Pharmacy: Pharmacy Phone:

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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	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> HEPATITIS A/B	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	
<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/> Pre-Med	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy	
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Recent Hospitalization	
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizures	
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Shingles	
<input type="checkbox"/> <input type="checkbox"/> Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	

Y N **Allergies**

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

Other

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)