

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:

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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 Conditions	Y N Conditions	Y N Conditions
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Taken Fen-Phen/Redux
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Artificial Bones	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Hepatitis C	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Human Papillomavirus	
<input type="checkbox"/> <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/> Medication For Osteoporosis	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Night Sweats	
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Pain In Jaw Joints	
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy	
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> <input type="checkbox"/> Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Seizures	
<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS	<input type="checkbox"/> <input type="checkbox"/> Stroke	

Y N Allergies
<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
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)