# 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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**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 |
| ☐ ☐ | Acid Reflux |
| ☐ ☐ | Allergies/Sinus Problems |
| ☐ ☐ | Anemia |
| ☐ ☐ | Angina Pectoris |
| ☐ ☐ | Arthritis |
| ☐ ☐ | Artificial Heart Valve |
| ☐ ☐ | Artificial Joint |
| ☐ ☐ | Asthma |
| ☐ ☐ | Blood Clot |
| ☐ ☐ | Blood Transfusion |
| ☐ ☐ | Cancer-Chemo Or Radiation Therap |
| ☐ ☐ | Colitis |
| ☐ ☐ | Congenital Heart Defect |
| ☐ ☐ | Congenital Heart Defect-Repaired |
| ☐ ☐ | Cyanotic Congenital Heart Disease |
| ☐ ☐ | Diabetes |
| ☐ ☐ | Difficulty Breathing |
| ☐ ☐ | Diverticulitis |
| ☐ ☐ | Drug/Alcohol Abuse |
| ☐ ☐ | Emphysema |
| ☐ ☐ | Epilepsy |

| Y N | Conditions |
|---|---|
| ☐ ☐ | Fainting Spells |
| ☐ ☐ | Fever Blisters |
| ☐ ☐ | Frequent Headaches |
| ☐ ☐ | Glaucoma |
| ☐ ☐ | HIV+ AIDS |
| ☐ ☐ | Heart Attack |
| ☐ ☐ | Heart Surgery |
| ☐ ☐ | Heart Transplant |
| ☐ ☐ | Hemophilia |
| ☐ ☐ | Hepatitis A, B, C (Circle One) |
| ☐ ☐ | High Blood Pressure |
| ☐ ☐ | History Of Infective Endocarditis |
| ☐ ☐ | Kidney Problems |
| ☐ ☐ | Liver Disease |
| ☐ ☐ | Low Blood Pressure |
| ☐ ☐ | Lupus |
| ☐ ☐ | Mitral Valve Prolapse |
| ☐ ☐ | Organ Transplant |
| ☐ ☐ | Osteoporosis |
| ☐ ☐ | Pace Maker |
| ☐ ☐ | Pain In Jaw Joints |
| ☐ ☐ | Psychiatric Problems |

| Y N | Conditions |
|---|---|
| ☐ ☐ | Seizures |
| ☐ ☐ | Sleep Apnea |
| ☐ ☐ | Stroke |
| ☐ ☐ | Thyroid Problems |
| ☐ ☐ | Tuberculosis |
| ☐ ☐ | Ulcers |

| 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)