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:***

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
☐	☐	Allergies/Sinus Problems
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joint
☐	☐	Asthma
☐	☐	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
☐	☐	Fainting Spells
☐	☐	Fever Blisters

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

Y	N	***Conditions***
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Acid Reflux
☐	☐	Sleep Apnea
☐	☐	

Y	N	***Allergies***
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

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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)