

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

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City State Zip:

Email:

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Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

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Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Physician Name:

Physician Phone:

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Pharmacy:

Pharmacy Phone:

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For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Please answer the following:

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|--|-----|--|
| | 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? |
|--|-----|--|

| | |
|--|---|
| Y N | <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco? Height: <input style="width: 60px;" type="text"/> |
| For Office Use Only | |
| BP <input style="width: 60px;" type="text"/> | Heart Rate: <input style="width: 60px;" type="text"/> Weight: <input style="width: 60px;" type="text"/> |

| 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"/> | Anorexia Or Bulimia |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <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"/> | Cold Sore |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <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"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |

| Y | N | <u>Conditions</u> |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Condition |
| <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"/> | Human Papillomavirus |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <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"/> | Other Condition Not Listed |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems |
| <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"/> | Sinus Problems |

| Y | N | <u>Conditions</u> |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring |
| <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 |

| 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 |
| 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)