

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:

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:	Please answer the following:
<input style="width: 50px;" type="text"/>	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: 50px;" type="text"/> For Office Use Only BP <input style="width: 50px;" type="text"/> Heart Rate: <input style="width: 50px;" type="text"/> Weight: <input style="width: 50px;" type="text"/>

Y N Conditions	Y N Conditions	Y N Conditions
<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"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> <input type="checkbox"/> Artificial Bones	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS	
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<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"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	
<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Pneumocystitis	
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy	
<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)