

PATIENT MEDICAL HISTORY

Patient's Name:

Date of Birth:

Today's Date:

Address:

City, State, Zip:

Home Phone:

Cell Phone:

Emergency Contact:

Emergency Contact Phone:

Your E-mail:

General Dentist:

Primary Care Physician:

Do You Have Dental Insurance **Yes** **No**

Primary Dental Insurance Company:

Subscriber's Employer:

Subscriber:

Name:

Subscriber ID/SSN#:

Subscribers DOB:

Self **Other**

Secondary Dental Insurance Company:

Subscribers Employer:

Subscriber:

Name:

Subscriber ID/SSN#:

Subscribers DOB:

Self **Other**

Notes:

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Patient's Name:

Date of Birth:

Sex:

[Empty box for Patient's Name]

[Empty box for Date of Birth]

[Empty box for Sex]

If female, please answer the following:

Please answer the following:

Y N
 Are you taking birth control pills?
 Are you pregnant? If yes, # of weeks:
 Are you nursing?

Y N
 Do you smoke/use tobacco? How much? _____
 Height: _____
 Weight: _____

Y	N	Conditions
<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"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (year) _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery (year) _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type) _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<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"/>	Osteoporosis Medication (within last 5 years)
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Pain In Jaw
<input type="checkbox"/>	<input type="checkbox"/>	Pain in joints
<input type="checkbox"/>	<input type="checkbox"/>	Radiation
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice

Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetic
<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
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Medications/Supplements:

[Empty box for Medications/Supplements]

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:

[Empty box for description of disease/condition]

Signature: _____ Date: _____

(If under 18, Parent or Guardian signature required)

For Office Use Only:

BP:

[BP box]

Heart Rate:

[Heart Rate box]

Medical Alerts:

[Empty box for Medical Alerts]