2024

PATIENT MEDICAL HISTORY

Patient's Name: | Date of Birth: | Today's Date:

Mailing 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: ☐ Self ☐ Other | Name: | Subscriber ID/SSN#: | Subscribers DOB:

Secondary Dental Insurance Company: | Subscribers Employer:

Subscriber: ☐ Self ☐ Other | Name: | Subscriber ID/SSN#: | Subscribers DOB:

Notes:

OVER--->

Patient's Name: | **Date of Birth:** | **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/use tobacco? How much?________

Height: ________________________

Weight: ________________________

Y	N	**Conditions**	Y	N	**Conditions**	Y	N	**Conditions**
☐	☐	Abnormal Bleeding	☐	☐	Hepatitis (type) ___________	☐	☐	Ulcers
☐	☐	Alcohol Abuse	☐	☐	High Blood Pressure	☐	☐	Venereal Disease
☐	☐	Allergies	☐	☐	Joint Replacement	☐	☐	Yellow Jaundice
☐	☐	Angina Pectoris	☐	☐	Kidney Disease			
☐	☐	Arthritis	☐	☐	Liver Disease	Y	N	**Allergies**
☐	☐	Asthma	☐	☐	Low Blood Pressure	☐	☐	Aspirin
☐	☐	Cancer	☐	☐	Mitral Valve Prolapse	☐	☐	Codeine
☐	☐	Chemotherapy	☐	☐	Osteoporosis Medication (within last 5 years)	☐	☐	Dental Anesthetic
☐	☐	Congenital Heart Defect	☐	☐	Pace Maker	☐	☐	Jewelry
☐	☐	Diabetes	☐	☐	Pain In Jaw	☐	☐	Latex
☐	☐	Difficulty Breathing	☐	☐	Pain in joints	☐	☐	Metals
☐	☐	Epilepsy	☐	☐	Radiation	☐	☐	Penicillin
☐	☐	Fainting Spells	☐	☐	Seizures	☐	☐	Tetracycline
☐	☐	Glaucoma	☐	☐	Sinus Problems	☐	☐	**Other:**
☐	☐	HIV+ AIDS	☐	☐	Stroke			______________________________
☐	☐	Heart Attack (year) _________	☐	☐	Thyroid Problems			______________________________
☐	☐	Heart Surgery (year) _________	☐	☐	Tuberculosis			
☐	☐	Heart Valve Replacement						

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:**

For Office Use Only:

BP:

Heart Rate:

Medical Alerts:

Signature: ____ **Date:** ___________

(If under 18, Parent or Guardian signature required)