PATIENT MEDICAL HISTORY

Patient's Name			

Address	Today's Date	Date of Last Visit	Date of Medical History

City State Zip	E-mail

Home Phone	Work Phone	DOB	Social Security No.	Marital Status
		/ /	- -	S/M/D/W

Primary Dental Guarantor	Home Phone	Work Phone

Secondary Dental Guarantor	Home Phone	Work Phone

Physician's Name	Physician's Phone

Pharmacy	Pharmacy Phone

For Office use Only
Medical Alerts:

Sex	If female please answer the following	All please answer the following
	Y N	Y N Height_______
	❐ ❐ Are you taking birth control pills?	❐ ❐ Do you use tobacco? Weight ______
	❐ ❐ Are you pregnant? If Yes, # of weeks ___	*For Office Use Only*
	❐ ❐ Are you nursing?	BP ______ Heart Rate _______

		Conditions			Conditions			Conditions
Y	N	Abnormal Bleeding	Y	N	HIV+ AIDS	Y	N	Stroke
Y	N	Alcohol Abuse	Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Allergies	Y	N	Heart Attack	Y	N	Tuberculosis
Y	N	Anemia	Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Angina Pectoris	Y	N	Hemophilia	Y	N	Venereal Disease
Y	N	Arthritis	Y	N	Hepatitis A	Y	N	Yellow Jaundice
Y	N	Artificial Heart Valve	Y	N	Hepatitis B			
Y	N	Artificial Joints	Y	N	High Blood Pressure			
Y	N	Asthma	Y	N	Kidney Problems			**Allergies**
Y	N	Blood Transfusion	Y	N	Liver Disease	Y	N	Aspirin
Y	N	Cancer – Chemotherapy	Y	N	Low Blood Pressure	Y	N	Codeine
Y	N	Colitis	Y	N	Mitral Valve Prolapse	Y	N	Dental Anesthetics
Y	N	Congenital Heart Defect	Y	N	Pace Maker	Y	N	Erythromycin
Y	N	Diabetes	Y	N	Pain in Jaw Joints	Y	N	Jewelry
Y	N	Difficulty Breathing	Y	N	Pneumocystitis	Y	N	Latex
Y	N	Drug Abuse	Y	N	Psychiatric Problems	Y	N	Metals
Y	N	Emphysema	Y	N	Radiation Therapy	Y	N	Penicillin
Y	N	Epilepsy	Y	N	Rhematic Fever	Y	N	Tetracycline
Y	N	Fainting Spells	Y	N	Seizures	Other_______________		
Y	N	Fever Blisters	Y	N	Shingles	____________________		
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease	____________________		
Y	N	Glaucoma	Y	N	Sinus Problems	____________________		

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.)