

# PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

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 or use tobacco?

Height:

For Office Use Only

BP  Heart Rate:

Weight:

Y N	Conditions
<input type="checkbox"/>	<input type="checkbox"/> Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/> Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Artificial Bones
<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"/> Colitis
<input type="checkbox"/>	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Difficulty Breathing
<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"/> Fever Blisters
<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"/> Hay Fever

Y N	Conditions
<input type="checkbox"/>	<input type="checkbox"/> Heart Attack
<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"/> 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"/> Pace Maker
<input type="checkbox"/>	<input type="checkbox"/> Pneumocystitis
<input type="checkbox"/>	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/> Radiation Therapy
<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"/> Sickle Cell Disease
<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"/> Premedicate
<input type="checkbox"/>	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Y N	Allergies
<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
<b>Other</b>	
_____	
_____	
_____	

**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)