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:** | **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:

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?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y N	Conditions
☐☐	Abnormal Bleeding
☐☐	Acid Reflux
☐☐	Alcohol Abuse
☐☐	Allergies
☐☐	Anemia
☐☐	Angina Pectoris
☐☐	Arthritis
☐☐	Artificial Bones
☐☐	Artificial Heart Valve
☐☐	Asthma
☐☐	Bishophonate/Fosamax Medicine
☐☐	Blood Transfusion
☐☐	Cancer- Chemotherapy
☐☐	Colitis
☐☐	Congenital Heart Defect
☐☐	Diabetes
☐☐	Difficulty Breathing
☐☐	Drug Abuse
☐☐	Dry Mouth
☐☐	Eating Disorder
☐☐	Emphysema
☐☐	Epilepsy

Y N	Conditions
☐☐	Fainting Spells
☐☐	Fever Blisters
☐☐	Frequent Headaches
☐☐	HBP Or HBP Medication
☐☐	HIV+ AIDS
☐☐	HPV Virus
☐☐	Heart Murmur
☐☐	Heart Surgery
☐☐	Hemophilia
☐☐	Hepatitis A
☐☐	Hepatitis B
☐☐	Hepatits C
☐☐	Infect. Endocarditis
☐☐	Kidney Problems
☐☐	Liver Disease
☐☐	Low Blood Pressure
☐☐	Osteoporosis Medicine
☐☐	Pace Maker
☐☐	Psychiatric Problems
☐☐	Radiation Therapy
☐☐	Seizures
☐☐	Shingles

Y N	Conditions
☐☐	Sinus Problems
☐☐	Sleep Apnea/Snoring
☐☐	Staph Infection
☐☐	Stroke / TIA
☐☐	Thyroid Problems
☐☐	Tuberculosis

Y N	Allergies
☐☐	Aspirin
☐☐	Codeine
☐☐	Dental Anesthetics
☐☐	Erythromycin
☐☐	Jewelry
☐☐	Latex
☐☐	Metals
☐☐	Penicillin
☐☐	Tetracycline

Other

_____

_____

_____

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)