

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: Male Female **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"/> | Alcohol Abuse |
| <input type="checkbox"/> <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> <input type="checkbox"/> | Artificial Joints/Bones |
| <input type="checkbox"/> <input type="checkbox"/> | Bisphosphonate(Actonel,Boniva,Fosamax) |
| <input type="checkbox"/> <input type="checkbox"/> | Blood Pressure High? Low? |
| <input type="checkbox"/> <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> <input type="checkbox"/> | Bruise Easily |
| <input type="checkbox"/> <input type="checkbox"/> | COPD, Asthma, Emphysema |
| <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"/> | Drug Abuse |
| <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 |

- | Y N | Conditions |
|---|-----------------------|
| <input type="checkbox"/> <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> | HIV + AIDS |
| <input type="checkbox"/> <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> <input type="checkbox"/> | Night Sweats |
| <input type="checkbox"/> <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> <input type="checkbox"/> | Pain in Jaw Joints |
| <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"/> | 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"/> | Yellow Jaundice |
| <input type="checkbox"/> <input type="checkbox"/> | Bleeding Gums? |
| <input type="checkbox"/> <input type="checkbox"/> | Brush? How often? |
| <input type="checkbox"/> <input type="checkbox"/> | Floss? |
| <input type="checkbox"/> <input type="checkbox"/> | Hepatitis A / B |
-
- | Y N | Allergies |
|---|--------------------|
| <input type="checkbox"/> <input type="checkbox"/> | Asprin |
| <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 |
| 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)