

# 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:**

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**Primary Dental Guarantor:**

**Home Phone:**

**Work Phone:**

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**Secondary Dental Guarantor:**

**Home Phone:**

**Work Phone:**

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**Physician Name:**

**Physician Phone:**

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**Pharmacy:**

**Pharmacy Phone:**

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**For Office Use Only**

**Medical Alerts:**

**Sex:**

**If female please answer the following:**

**Please answer the following:**

	Y N		
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	If Yes, # of weeks <input style="width: 30px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	

Y N			Height: <input style="width: 50px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?	
<b>For Office Use Only</b>			Weight: <input style="width: 50px;" type="text"/>
BP	<input style="width: 50px;" type="text"/>	Heart Rate: <input style="width: 50px;" type="text"/>	

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<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 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

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<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"/>	HIV+ AIDS
<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

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice

  

Y	N	<u>Allergies</u>
<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:**

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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...

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**Notes:**

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**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(If Under 18, Parent or Guardian Signature Required)