

# 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?  
**For Office Use Only**  
 BP:  Heart Rate:  Height:   
 Weight:

- | Y                        | N                        | Conditions              |
|--------------------------|--------------------------|-------------------------|
| <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                        | Conditions            |
|--------------------------|--------------------------|-----------------------|
| <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                        | Conditions       |
|--------------------------|--------------------------|------------------|
| <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                        | 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:**

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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)