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?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y	N	Conditions
☐	☐	YES Answers/Explain On Page 2
☐	☐	Had A Physical In Last 12 Mths
☐	☐	Acid Reflux/G.E.R.D.
☐	☐	Alcohol/Recreational Drug Use
☐	☐	Allergies
☐	☐	Arthritis / Rheumatism
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints Or Limbs
☐	☐	Asthma / COPD / Emphysema
☐	☐	Bacterial Endocarditis
☐	☐	Bleeding Issue-Meds Or Illness
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemo Or Radiation
☐	☐	Congenital Heart Defect
☐	☐	Diabetes Type 1 Type II
☐	☐	Difficulty Chewing/Swallowing
☐	☐	Dry Mouth Problems
☐	☐	Epilepsy / Seizure Disorders
☐	☐	Eye Diseases
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	HIV+ AIDS

Y	N	Conditions
☐	☐	Heart Attack
☐	☐	Heart Condition / Angina
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Hospitalized In The Last Year
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis-Taken Medication
☐	☐	Other Immune Deficiency Disease
☐	☐	Pace Maker
☐	☐	Pain In Jaw Joints
☐	☐	Psychiatric Problems
☐	☐	Sinus Problems
☐	☐	Skin Diseases
☐	☐	Stroke

Y	N	Conditions
☐	☐	Surgeries - List On Page 2
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers / Stomach Problems
☐	☐	
☐	☐	

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

Other

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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)