

# 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:

<p>Y N <b>Conditions</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Bones</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic Obstructive Pulmonary Disc</p> <p><input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p>	<p>Y N <b>Conditions</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis A</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Pace Maker</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumocystitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p>	<p>Y N <b>Conditions</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice</p> <div style="border: 2px solid black; padding: 5px; margin-top: 10px;"> <p>Y N <b>Allergies</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine</p> <p><input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics</p> <p><input type="checkbox"/> <input type="checkbox"/> Erythromycin</p> <p><input type="checkbox"/> <input type="checkbox"/> Jewelry</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex</p> <p><input type="checkbox"/> <input type="checkbox"/> Metals</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> <input type="checkbox"/> Tetracycline</p> <p><b>Other</b></p> <p>_____</p> <p>_____</p> <p>_____</p> </div>
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**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)