

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address: Today's Date: Date of Last Visit: Date of Med. History:

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City State Zip: Email:

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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:**

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: 50px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	

Please answer the following:

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

- | Y | N | Conditions |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal BP |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones/Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/Bruising Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer- Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone/Steroids |
| <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/Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |

- | Y | N | Conditions |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A,B Or C |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems/Dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |

- | Y | N | Conditions |
|--------------------------|--------------------------|------------------|
| <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 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | |
-
- | 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 |
| Other | | |
| _____ | | |
| _____ | | |
| _____ | | |

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)