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
☐	☐	Under A Physician's Care Now
☐	☐	Take Antibiotics For Dental Appts
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defect
☐	☐	Infectious Endocarditis
☐	☐	Osteoporosis
☐	☐	Take Osteoporosis Drugs
☐	☐	Diabetes
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Hepatits D
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Use An Inhaler
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Cancer

Y	N	Conditions
☐	☐	Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Glaucoma
☐	☐	Frequent Headaches
☐	☐	Herpes/Fever Blisters/Cold Sores
☐	☐	Heart Attack
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Pace Maker
☐	☐	Liver Disease
☐	☐	Pain In Chest
☐	☐	Swollen Ankles
☐	☐	Rheumatic/Scarlet Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Y	N	Conditions
☐	☐	HIV
☐	☐	AIDS
☐	☐	Kidney Problems
☐	☐	Drug Or Alcohol Addiction
☐	☐	Dental Anxiety
☐	☐	Sulfa Allergy

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

Other

_____

_____

_____

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)