

# 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:

<b>Sex:</b>	<b>If female please answer the following:</b>	<b>Please answer the following:</b>
<input style="width: 60px; height: 25px;" type="text"/>	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: 30px;" type="text"/> <input type="checkbox"/> <input type="checkbox"/> Are you nursing?	Y N <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco? Height: <input style="width: 60px;" type="text"/> <b>For Office Use Only</b> BP <input style="width: 40px;" type="text"/> Heart Rate: <input style="width: 40px;" type="text"/> Weight: <input style="width: 60px;" type="text"/>

Y N <u>Conditions</u>	Y N <u>Conditions</u>	Y N <u>Conditions</u>
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Gums Swollen/Tender	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Bad Breath	<input type="checkbox"/> <input type="checkbox"/> Hepatitis C	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Blisters On Lips Or Mouth	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Lip/Cheek Biting	
<input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Shingles	
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Smoke	
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Stroke	
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	

Y N **Allergies**

Aspirin

Codeine

Dental Anesthetics

Erythromycin

Jewelry

Latex

Metals

Penicillin

Tetracycline

**Other**

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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:** \_\_\_\_\_  
(If Under 18, Parent or Guardian Signature Required)

**Date:** \_\_\_\_\_