

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:

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: 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: 50px;" type="text"/>
For Office Use Only			Weight:	<input style="width: 50px;" type="text"/>
BP	<input style="width: 30px;" type="text"/>	Heart Rate:	<input style="width: 30px;" type="text"/>	

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint/Bone
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Cancer- Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine
<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"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters/Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches

Y	N	<u>Conditions</u>
<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 Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis ABC
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<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

Y	N	<u>Allergies</u>
<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)