

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:

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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:

- | Y | N | Conditions |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <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"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorder |
| <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"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | G.E. Reflux/Persistent Heartburn |
| <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 Surgery |

- | Y | N | Conditions |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis Medication(Fosamax |
| <input type="checkbox"/> | <input type="checkbox"/> | IV Bisphosphonate(Aredia Or Zome |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Health Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems/Colitis/Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |

- | Y | N | Conditions |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Auto Immune Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Infective Endocarditis |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | <input type="checkbox"/> | PREMEDICATION |

- | 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)