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:**

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?

Height:

For Office Use Only
BP | Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Auto Immune Disorders
☐	☐	Blood Donor Ineligible
☐	☐	Cancer
☐	☐	Chemotheraphy
☐	☐	Radiation Therapy
☐	☐	Colitis
☐	☐	C-Diff
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Epilepsy/Seizures
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Chest Pains
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Congenital Heart Defect
☐	☐	Heart Attack

Y	N	Conditions
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Infective Endocarditis
☐	☐	Hepatitis
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Joint Replacement Theraphy
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lyme's Disease
☐	☐	Psychiatric Problems
☐	☐	Stroke/TIA
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Yellow Jaundice
☐	☐	STD's
☐	☐	Sleep Apnea

Y	N	Conditions
☐	☐	Snoring
☐	☐	Waking During The Night
☐	☐	General Fatigue - Exhaustion
☐	☐	Trouble Staying Awake
☐	☐	Frequent Headaches
☐	☐	

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)