

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?

Height:

For Office Use Only

BP Heart Rate:

Weight:

<p>Y N Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis-(Type) ___</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Bones</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p>	<p>Y N Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint Replacement (Knee Or Hip)</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Pace Maker</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumocystitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice</p>	<p>Y N Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <div style="border: 2px solid black; padding: 5px; margin-top: 10px;"> <p>Y N Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine</p> <p><input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics</p> <p><input type="checkbox"/> <input type="checkbox"/> Erythromycin</p> <p><input type="checkbox"/> <input type="checkbox"/> Jewelry</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex</p> <p><input type="checkbox"/> <input type="checkbox"/> Metals</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> <input type="checkbox"/> Tetracycline</p> <p>Other</p> <p>_____</p> <p>_____</p> <p>_____</p> </div>
---	---	--

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)