PATIENT MEDICAL HISTORY

Patient's Name:

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:**

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:

Weight:

Y	N	**Conditions**	Y	N	**Conditions**	Y	N	**Conditions**
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Alcohol Abuse	☐	☐	Hay Fever	☐	☐	Thyroid Problems
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Heart Surgery	☐	☐	Ulcers
☐	☐	Angina Pectoris	☐	☐	Hemophilia	☐	☐	Venereal Disease
☐	☐	Arthritis	☐	☐	Hepatitis A	☐	☐	Yellow Jaundice
☐	☐	Artificial Bones	☐	☐	Hepatitis B			
☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure			
☐	☐	Asthma	☐	☐	HIV+ AIDS	Y	N	**Allergies**
☐	☐	Blood Transfusion	☐	☐	Kidney Problems	☐	☐	Aspirin
☐	☐	Cancer- Chemotherapy	☐	☐	Liver Disease	☐	☐	Codeine
☐	☐	Colitis	☐	☐	Low Blood Pressure	☐	☐	Dental Anesthetics
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐	Erythromycin
☐	☐	Cosmetic Surgery	☐	☐	Pace Maker	☐	☐	Jewelry
☐	☐	Diabetes	☐	☐	Pneumocystitis	☐	☐	Latex
☐	☐	Difficulty Breathing	☐	☐	Psychiatric Problems	☐	☐	Metals
☐	☐	Drug Abuse	☐	☐	Radiation Therapy	☐	☐	Penicillin
☐	☐	Emphysema	☐	☐	Rheumatic Fever	☐	☐	Tetracycline
☐	☐	Epilepsy	☐	☐	Seizures			**Other**
☐	☐	Fainting Spells	☐	☐	Shingles			
☐	☐	Fever Blisters	☐	☐	Sickle Cell Disease			
☐	☐	Frequent Headaches	☐	☐	Sinus Problems			

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)