

# 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:

Y N	Conditions	Y N	Conditions	Y N	Conditions
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	GURD	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	
<input type="checkbox"/>	Alzheimers/Dementia	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	
<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	
<input type="checkbox"/>	Bishphonates (Fosomax, Boniva)	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	
<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Human Papilloma Virus (HPV)	<input type="checkbox"/>	
<input type="checkbox"/>	Cancer- Chemotherapy	<input type="checkbox"/>	Hypothyroid Or Hyperthyroid	<input type="checkbox"/>	
<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	
<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	
<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	
<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Pneumocystitis	<input type="checkbox"/>	
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	
<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	
<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	

Y N **Allergies**

Aspirin

Codeine

Dental Anesthetics

Erythromycin

Jewelry

Latex

Metals

Penicillin

Tetracycline

**Other**

\_\_\_\_\_

\_\_\_\_\_

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**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: \_\_\_\_\_  
(If Under 18, Parent or Guardian Signature Required)

Date: \_\_\_\_\_