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:

Weight:

For Office Use Only
BP Heart Rate

Y	N	Conditions
☐	☐	Pre Medicate
☐	☐	Auto Immune Disorder
☐	☐	Arthritis
☐	☐	Taken Bisphosphonates
☐	☐	Joint Replacement
☐	☐	Low Blood Pressure
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Rheumatic Fever
☐	☐	Mitral Valve Prolapse
☐	☐	Heart Surgery
☐	☐	Pace Maker
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defect
☐	☐	Angina Pectoris
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Blood Transfusion
☐	☐	Bruise Easily
☐	☐	Diabetes
☐	☐	Cancer- Chemotherapy
☐	☐	Radiation Therapy

Y	N	Conditions
☐	☐	Allergies
☐	☐	Sinus Problems
☐	☐	Asthma
☐	☐	Hay Fever
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Stroke
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	GI Problems
☐	☐	Ulcers
☐	☐	Colitis
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Psychiatric Problems

Y	N	Conditions
☐	☐	Alcohol Abuse
☐	☐	Drug Abuse
☐	☐	Thyroid Problems
☐	☐	Frequent Headaches
☐	☐	Pain In Jaw Joints
☐	☐	Other (Next Page)

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

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