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
☐ ☐	Abnormal Bleeding
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Dental Implants
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Hay Fever
☐ ☐	Hearing Loss

Y N	Conditions
☐ ☐	Heart Disease
☐ ☐	Heart Surgery
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	Immune Suppressed Disorder
☐ ☐	Joint Replacement/Artificial Joints
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Major Surgery- Last 2years
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pain In Jaw Joints
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sinus Problems
☐ ☐	Stroke
☐ ☐	Take Antibiotic Prior To Dental Tx.
☐ ☐	Thyroid Problems

Y N	Conditions
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Have You Taken Bisphosphonate
☐ ☐	Recent Hospitalizations
☐ ☐	Have You Take Bisphosphonate

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)