

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:

Unknown

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

- Environmental Allergies
- Sinus Problems
- Artificial Heart Valve
- Heart Murmur
- Heart Surgery
- Pace Maker
- Mitral Valve Prolapse
- Congenital Heart Defect
- Asthma
- Arthritis
- Anemia
- Blood Transfusion
- Hepatitis- Type ___
- Hemophilia
- HIV+ AIDS
- Bruise Easily
- Cancer- Chemotherapy
- Cerebral Palsey
- Spina Bifida
- Colitis
- Diabetes
- Difficulty Breathing

Y N

Conditions

- Eeczma Or Psoriasis
- Emotional Or Behavioral Problems
- Learning Disorder
- ADHD
- Autistic
- Psychiatric Problems
- Physical Abuse
- Fainting Spells
- Fever Blisters
- Frequent Ear Infections
- Frequent Headaches
- High Blood Pressure
- Low Blood Pressure
- Immunologic Concerns
- Kidney Problems
- Liver Disease
- Measles/Mumps/Chicken Pox
- Rheumatic/Scarlet Fever
- Radiation Therapy
- Reflux/Vomiting
- Seizures Or Epilepsy
- Sickle Cell Disease

Y N

Conditions

- Strep Throat Or Tonsillitis
- Tuberculosis
- Ulcers
- Consent For Treatment Given
- Nitrous Oxide Consent Given
-
-

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)