

# 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		
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	If Yes, # of weeks <input style="width: 40px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	

Please answer the following:

Y	N		
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?	Height: <input style="width: 60px;" type="text"/>
<b>For Office Use Only</b>			Weight: <input style="width: 60px;" type="text"/>
BP	<input style="width: 20px;" type="text"/>	/	<input style="width: 20px;" type="text"/>
Heart Rate:	<input style="width: 60px;" type="text"/>		

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint/Bone
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Pain In Jaw Joints
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	

Y	N	<u>Allergies</u>
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<b>Other</b>		
<input style="width: 100%;" type="text"/>		
<input style="width: 100%;" type="text"/>		
<input style="width: 100%;" type="text"/>		

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