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?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	*Bad Breath
☐	☐	*Bite Lips/Cheeks
☐	☐	*Bleeding Gums
☐	☐	*Blisters On Mouth
☐	☐	*Dry Mouth
☐	☐	*Food Collection
☐	☐	*Grinding Teeth
☐	☐	*Pain Ear/Jaw
☐	☐	*Sleep Problems
☐	☐	ALZHEIMERS DEMENTIA
☐	☐	ARTIFICIAL JOINT
☐	☐	Alcohol/Drug Abuse
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma/Copd
☐	☐	BACTERIAL ENDOCARDITIS
☐	☐	BLOOD THINNERS
☐	☐	Back Problems
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Chest Pain
☐	☐	Circulatory Problems

Y	N	Conditions
☐	☐	Congenital Heart
☐	☐	DIABETIC
☐	☐	Dialysis
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	HEART PROBLEM
☐	☐	HEART-ARTIFICIAL VALVE
☐	☐	HIV/AIDS
☐	☐	Hepatitis
☐	☐	Herpes or Shingles
☐	☐	High Blood Pressure
☐	☐	Immune Suppression
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Nervous / Anxious
☐	☐	Osteoporosis
☐	☐	PREMED
☐	☐	Pacemaker
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Shunts / Stents

Y	N	Conditions
☐	☐	Sinus Problems
☐	☐	Sjogren's Syndrome
☐	☐	Stroke
☐	☐	Surgeries
☐	☐	Thyroid Problems
☐	☐	Tuberculosis

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)