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**	Y	N	**Conditions**	Y	N	**Conditions**
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Alcohol Abuse	☐	☐	HIV+ AIDS	☐	☐	Thyroid Problems
☐	☐	Allergies	☐	☐	Hay Fever	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Heart Attack	☐	☐	Ulcers
☐	☐	Angina Pectoris	☐	☐	Heart Murmur	☐	☐	Venereal Disease
☐	☐	Arthritis	☐	☐	Heart Surgery	☐	☐	Antibiotic Premedication
☐	☐	Artificial Bones	☐	☐	Hemophilia			
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis A			
☐	☐	Asthma	☐	☐	Hepatitis B			
☐	☐	Blood Transfusion	☐	☐	High Blood Pressure			
☐	☐	Cancer- Chemotherapy	☐	☐	Kidney Problems			
☐	☐	Colitis	☐	☐	Liver Disease			
☐	☐	Congenital Heart Defect	☐	☐	Low Blood Pressure			
☐	☐	Cosmetic Surgery	☐	☐	Mitral Valve Prolapse			
☐	☐	Diabetes	☐	☐	Pace Maker			
☐	☐	Difficulty Breathing	☐	☐	Pain In Jaw Joints			
☐	☐	Drug Abuse	☐	☐	Psychiatric Problems			
☐	☐	Emphysema	☐	☐	Radiation Therapy			
☐	☐	Epilepsy	☐	☐	Rheumatic Fever			
☐	☐	Fainting Spells	☐	☐	Seizures			
☐	☐	Fever Blisters	☐	☐	Shingles			
☐	☐	Frequent Headaches	☐	☐	Sinus Problems			

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

Other

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