

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?

Height:

For Office Use Only

BP: Heart Rate:

Weight:

<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;">Y</th> <th style="width: 5%;">N</th> <th style="width: 90%;"><u>Conditions</u></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Lung Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies/Hayfever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bruise Easily</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer- Chemotherapy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chest Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cold/Virus</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emphysema</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting Spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fever Blisters</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent Headaches</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HIV+ AIDS</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Attack</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Murmur</td></tr> </tbody> </table>	Y	N	<u>Conditions</u>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Cancer- Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold/Virus	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<table style="width: 100%; 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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)