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:

Y	N	Conditions
☐	☐	Bleeding Gums
☐	☐	Gums Swollen Or Tender
☐	☐	Loose Teeth Or Broken Filling
☐	☐	Tooth Sensitivity To Cold
☐	☐	Tooth Sensitivity To Hot
☐	☐	Tooth Sensitivty To Sweets
☐	☐	Sensitivity To Biting
☐	☐	Food Collection Between Teeth
☐	☐	Mouth Ulcers/Fever Blisters
☐	☐	Dry Mouth
☐	☐	Pain In Jaw Joints
☐	☐	Grinding Teeth
☐	☐	Pain With 3rd Molars
☐	☐	Orthodontic Treatment
☐	☐	Periodontal Treatment
☐	☐	Sinus Problems
☐	☐	Angina Pectoris
☐	☐	Difficulty Breathing
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defect
☐	☐	Heart Attack
☐	☐	Heart Surgery

Y	N	Conditions
☐	☐	Mitral Valve Prolapse
☐	☐	Rheumatic Fever
☐	☐	Pace Maker
☐	☐	Asthma
☐	☐	Tuberculosis
☐	☐	Arthritis
☐	☐	Artifical Joints
☐	☐	Diabetes
☐	☐	Kidney Problems
☐	☐	Thyroid Problems
☐	☐	Glaucoma
☐	☐	Hepatitis
☐	☐	Stroke
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Frequent Headaches
☐	☐	Anemia
☐	☐	Abnormal Bleeding
☐	☐	Hemophilia
☐	☐	Sickle Cell Disease
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure

Y	N	Conditions
☐	☐	Alcohol Abuse
☐	☐	Drug Abuse
☐	☐	HIV+ AIDS
☐	☐	Radiation Therapy
☐	☐	Cancer- Chemotherapy
☐	☐	Venereal Disease

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)