PATIENT MEDICAL HISTORY

Patient's Name:

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:**

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: ☐
Weight: ☐

Y N	**Conditions**	Y N	**Conditions**	Y N	**Conditions**
☐ ☐	Abnormal Bleeding	☐ ☐	Heart Surgery	☐ ☐	Stroke
☐ ☐	Actonel/Boniva/Fosamax	☐ ☐	Hemophilia	☐ ☐	Thyroid Problems
☐ ☐	Alcohol/Drug Abuse	☐ ☐	Hepatitis A	☐ ☐	Tuberculosis
☐ ☐	Anemia	☐ ☐	Hepatitis B	☐ ☐	Ulcers
☐ ☐	Arthritis	☐ ☐	Herpes/Fever Blisters	☐ ☐	Venereal Disease
☐ ☐	Artificial Bones/Joints/Valves	☐ ☐	High Blood Pressure	☐ ☐	
☐ ☐	Asthma	☐ ☐	High Cholesterol		
☐ ☐	Autoimmune Issues	☐ ☐	Hospitalized For Any Reason		
☐ ☐	Blood Transfusion	☐ ☐	Kidney Problems		
☐ ☐	Cancer- Chemotherapy	☐ ☐	Liver Disease		
☐ ☐	Colitis	☐ ☐	Low Blood Pressure		
☐ ☐	Congenital Heart Defect	☐ ☐	Mitral Valve Prolapse		
☐ ☐	Diabetes	☐ ☐	Osteoporosis		
☐ ☐	Difficulty Breathing	☐ ☐	Pace Maker		
☐ ☐	Dye/SLS Sensitivity	☐ ☐	Psychiatric Problems		
☐ ☐	Epilepsy	☐ ☐	Radiation Therapy		
☐ ☐	Fainting Spells	☐ ☐	Rheumatic Fever		
☐ ☐	Food Allergies	☐ ☐	Seizures		
☐ ☐	Frequent Headaches	☐ ☐	Shingles		
☐ ☐	HIV+ AIDS	☐ ☐	Sinus Problems		
☐ ☐	Heart Attack	☐ ☐	Sleep Apnea		
☐ ☐	Heart Murmur	☐ ☐	Snoring		

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)