

# PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

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City State Zip:

Email:

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Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

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Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Physician Name:

Physician Phone:

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Pharmacy:

Pharmacy Phone:

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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

- ☐ ☐ Alcohol Abuse
- ☐ ☐ Allergies
- ☐ ☐ Anemia
- ☐ ☐ Angina Pectoris
- ☐ ☐ Arthritis
- ☐ ☐ Artificial Joint/Valve
- ☐ ☐ Asthma
- ☐ ☐ Blood Disorder
- ☐ ☐ Cancer- Chemotherapy
- ☐ ☐ Colitis
- ☐ ☐ Diabetes
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Drug Abuse
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy
- ☐ ☐ Fainting Spells
- ☐ ☐ Frequent Headaches
- ☐ ☐ HIV+ AIDS
- ☐ ☐ Hay Fever
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Condition
- ☐ ☐ Hemophilia

Y N

Conditions

- ☐ ☐ Hepatitis A
- ☐ ☐ Hepatitis B
- ☐ ☐ Hepatitis C
- ☐ ☐ High Blood Pressure
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Pace Maker
- ☐ ☐ Pain In Jaw Joints
- ☐ ☐ Premedication Needed
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Radiation Therapy
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Seizures
- ☐ ☐ Sinus Problems
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease
- ☐ ☐ Yellow Jaundice

Y N

Conditions

- ☐ ☐
- ☐ ☐
- ☐ ☐
- ☐ ☐
- ☐ ☐
- ☐ ☐
- ☐ ☐

Y N

Allergies

- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Dental Anesthetics
- ☐ ☐ Erythromycin
- ☐ ☐ Jewelry
- ☐ ☐ Latex
- ☐ ☐ Metals
- ☐ ☐ Penicillin
- ☐ ☐ Tetracycline

Other

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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:** \_\_\_\_\_  
(If Under 18, Parent or Guardian Signature Required)

**Date:** \_\_\_\_\_