# 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?

**For Office Use Only**
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

| Y N | Conditions |
|---|---|
| ☐ ☐ | Abnormal Bleeding |
| ☐ ☐ | Anemia |
| ☐ ☐ | Angina Pectoris |
| ☐ ☐ | Arthritis |
| ☐ ☐ | Asthma |
| ☐ ☐ | Blood Disorders |
| ☐ ☐ | Cancer- Chemotherapy |
| ☐ ☐ | Colitis |
| ☐ ☐ | Diabetes |
| ☐ ☐ | Emphysema |
| ☐ ☐ | Fainting Seizures |
| ☐ ☐ | Fever Blisters |
| ☐ ☐ | Frequent Headaches |
| ☐ ☐ | Gastrointes Prob/Ulcers |
| ☐ ☐ | Glaucoma |
| ☐ ☐ | HIV+ AIDS |
| ☐ ☐ | Hay Fever |
| ☐ ☐ | Heart Surgery |
| ☐ ☐ | Heart Attack |
| ☐ ☐ | Heart Conditions |
| ☐ ☐ | Heart Murmur |
| ☐ ☐ | Hepatitis Jaundice |

| Y N | Conditions |
|---|---|
| ☐ ☐ | High Blood Pressure |
| ☐ ☐ | Joint Replacements |
| ☐ ☐ | Kidney Problems |
| ☐ ☐ | Liver Disease |
| ☐ ☐ | Low Blood Pressure |
| ☐ ☐ | Pace Maker |
| ☐ ☐ | Pneumonia |
| ☐ ☐ | Psychiatric Problems |
| ☐ ☐ | Radiation Therapy |
| ☐ ☐ | Respiratory Problems |
| ☐ ☐ | Rheumatic Fever |
| ☐ ☐ | Sex Trans Disease |
| ☐ ☐ | Shingles |
| ☐ ☐ | Sinus Problems |
| ☐ ☐ | Stroke |
| ☐ ☐ | Thyroid Problems |
| ☐ ☐ | Tuberculosis |
| ☐ ☐ | Bleeding Gums |
| ☐ ☐ | Teeth Hot/Cold Sensitive |
| ☐ ☐ | SourSweet Sensitive |
| ☐ ☐ | Teeth Grinding |
| ☐ ☐ | Jaw, Head NeckInjury |

| Y N | Conditions |
|---|---|
| ☐ ☐ | Jaw Click / Jaw Pain |
| ☐ ☐ | Oral Hygie Instructions? |
| ☐ ☐ | Do U Like Your Smile |
| ☐ ☐ | Use Dentures Or Partials |
| ☐ ☐ | |
| ☐ ☐ | |

| 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)