PATIENT MEDICAL HISTORY

Patient's Name:

Address:

City State Zip: Email:

Home Phone: Work/cell phone: Birthdate: SSN# or Insurance ID#

Primary Dental Guarantor: Home Phone: Work Phone:

Secondary Dental Guarantor: Home Phone: Work Phone:

Physician Name: Physician Phone:

Pharmacy: Pharmacy Phone:

If female please answer the following:
Y N Are you taking Birth Control Pills?
Y N Are you pregnant? If yes, # weeks__
Y N Are you nursing?

Please answer the following:
Y N Do you smoke or use tobacco?
Height____ Weight____

Conditions	Conditions	Conditions
Y N Abnormal Bleeding	Y N HIV+ AIDS	Y N Shingles
Y N Alcohol Abuse	Y N Heart Attack	Y N Sickle Cell Disease
Y N Allergies	Y N Heart Murmur	Y N Sinus Problems
Y N Anemia	Y N Heart Surgery	Y N Stroke
Y N Angina Pectoris	Y N Hemophilia	Y N Thyroid Problems
Y N Arthritis	Y N Hepatitis A	Y N Tuberculosis
Y N Artificial Bones	Y N Hepatitis B	Y N Ulcers
Y N Artificial Heart Valve	Y N Hepatitis C	Y N Venereal Disease
Y N Asthma	Y N High Blood Pressure	Y N Yellow Jaundice
Y N Blood Transfusion	Y N Kidney Problems	**Allergies:**
Y N Cancer-Chemotherapy	Y N Liver Disease	Y N Aspirin
Y N Colitis	Y N Low Blood Pressure	Y N Codeine
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Dental
Y N Diabetes	Y N Pace Maker	Anesthetics
Y N Difficulty Breathing	Y N Pneumocystitis	Y N Erythromycin
Y N Drug Abuse	Y N Psychiatric Problems	Y N Jewelry
Y N Emphysema	Y N Radiation Therapy	Y N Latex
Y N Epilepsy	Y N Rheumatic Fever	Y N Metals
Y N Fainting Spells	Y N Seizures	Y N Penicillin
		Y N Tetracycline

Medications:

Circle One:

Yes No 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:

Signature:_____ Date:_____

(If under 18, Parent or Guardian Signature Required)