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
☐ ☐	Chest Pains
☐ ☐	Difficulty Breathing:_____
☐ ☐	Heart Condition Or Surgery_____
☐ ☐	Pace Maker
☐ ☐	Rheumatic Fever
☐ ☐	Stroke Date:_____
☐ ☐	Anemia
☐ ☐	Blood Pressure- High/Low _____
☐ ☐	Blood Transfusion_____
☐ ☐	Bruise Easily
☐ ☐	Hemophilia
☐ ☐	Diabetes Type:_____
☐ ☐	Abnormal Bleeding
☐ ☐	Epilepsy/ Fainting Spells/ Siezures
☐ ☐	Asthma
☐ ☐	Hay Fever
☐ ☐	Sinus Problems
☐ ☐	Ulcers
☐ ☐	Kidney Or Bladder Problems
☐ ☐	Eating Disorder/ Special Diet
☐ ☐	Arthritis
☐ ☐	Autoimmune Disease:_____

Y N	Conditions
☐ ☐	Back/ Neck Pain
☐ ☐	Joint Replacemant Type/Date:____
☐ ☐	Implants (Breast/Hip/Knee):
☐ ☐	Headaches Frequent Or Severe
☐ ☐	Tuberculosis/ Breathing Issues:___
☐ ☐	Cancer Type/Date:_____
☐ ☐	Treatment Type/Date;_____
☐ ☐	Family History Of Oral Cancer
☐ ☐	Thyroid Problems
☐ ☐	Hepatitis A, B, Or C
☐ ☐	Liver Disease
☐ ☐	Persistent Cough/ Swollen Glands?
☐ ☐	Glaucoma
☐ ☐	Shingles
☐ ☐	HIV+ AIDS
☐ ☐	Fever Blisters
☐ ☐	Do You Snore?
☐ ☐	Sleep Apnea?
☐ ☐	Dry Mouth
☐ ☐	Jaw: Pain/ Popping/ Injury/ Locked:_
☐ ☐	Concerned With Bad Breath?
☐ ☐	Unhappy With Look/ Color Of Teeth

Y N	Conditions
☐ ☐	Do You Gag Easily: Y/N
☐ ☐	Sensitivity To Hot/Cold/Chewing?__
☐ ☐	Alcohol/ Drug Abuse?_____
☐ ☐	Do You Vape?
☐ ☐	Recreational Drug Use?
☐ ☐	PreMed For Dental Appts Y/N?

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)