

PATIENT MEDICAL HISTORY

Today's date: _____

Date of your last visit? _____

Patient Name _____

Address _____

City, State, Zip _____ E-mail: _____

Home phone: _____ Cell: _____ Birthday: _____ S.S. # _____

Martial Status: Married, divorced, Single, Widowed

Primary Dental Guarantor: _____ Secondary dental Guarantor: _____

Physician Name: _____ Physician phone: _____

Pharmacy: _____ Pharmacy phone: _____

Who may we thank for referring you to our office? _____

Sex: Male / Female (If female please answer the following)

Y N Are you taking birth control pills?

Y N Are you pregnant? If yes # of weeks _____

Y N Are you nursing?

Please answer the following?

Y N Do you smoke or use tobacco?

Y N Do you use Alcohol products?(if yes how much?) _____

Conditions

Y N Abnormal bleeding
 Y N Alcohol Abuse
 Y N Allergies
 Y N Anemia
 Y N Angina Pectoris
 Y N Arthritis
 Y N Artificial bones
 Y N Artificial heart valve
 Y N Asthma
 Y N Blood transfusion
 Y N Cancer/chemotherapy
 Y N Colitis
 Y N Congenital heart
 Y N Cosmetic Surgery
 Y N Diabetes
 Y N Difficulty breathing
 Y N Drug Abuse
 Y N Emphysema
 Y N Epilepsy
 Y N Fainting spells
 Y N Fever Blisters
 Y N Frequent Headaches

Conditions

Y N Glaucoma
 Y N Hay fever
 Y N Heart attack
 Y N Heart Surgery
 Y N Hemophilia
 Y N Hepatitis A
 Y N Hepatitis B
 Y N High blood pressure
 Y N HIV/Aids
 Y N Kidney problems
 Y N Liver disease
 Y N Low blood pressure
 Y N Mitral Valve Prolapse
 Y N Pace Maker
 Y N Pneumocysus
 Y N Psychiatric problems
 Y N Radiation Therapy
 Y N Rneumatic Therapy
 Y N Seizures
 Y N Shingles
 Y N Sickle Disease
 Y N Sinus Problems

Conditions

Y N Stroke
 Y N Thyroid problems
 Y N Tuberculosis
 Y N Ulcers
 Y N Venereal Disease
 Y N Yellow Jaundice

Allergies

Y N Aspirin
 Y N Codeine
 Y N Anesthetics
 Y N Erythromycin
 Y N Jewelry
 Y N Latex
 Y N Metals
 Y N Penicillin
 Y N Tetracycline
 Y N Sulfa

Medications

 Y N is there any disease, condition or problem that you think this office should know about that was not covered in your paperwork? (if yes, please describe below...)

Notes:

Signature: _____ Date: _____

(If under 18, parent or guardian signature required)