

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:

Birth Date:

Social Security No.:

Marital Status:

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Primary Dental Guarantor:

Home Phone:

Work Phone:

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Secondary Dental Guarantor:

Home Phone:

Work 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:

<table style="width: 100%;"> <tr> <th style="text-align: left;">Y N</th> <th style="text-align: left;"><u>Conditions</u></th> </tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/> <input 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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: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)