

**PATIENT MEDICAL HISTORY**

**Patient's Name:**

**Date of Birth:**

**Today's Date:**




**Address:**

**City, State Zip:**



**Home Phone:**

**Work Phone:**

**Cell Phone:**




**Marital Status:**

**E-mail:**



**General Dentist:**

**Primary Care Physician:**



**Do You Have Dental Insurance**     **Yes**     **No**

**Primary Dental Insurance Company:**

**Subscriber's Employer:**



**Subscriber:**

**Name:**

**Subscriber ID/SSN#:**

**Subscribers DOB:**

**Self**     **Other**




**Secondary Dental Insurance Company:**

**Subscribers Employer:**



**Subscriber:**

**Name:**

**Subscriber ID/SSN#:**

**Subscribers DOB:**

**Self**     **Other**




**Notes:**

Patient's Name:

Date of Birth:

Sex:

[Empty box for Patient's Name]

[Empty box for Date of Birth]

[Empty box for Sex]

If female, please answer the following:

Please answer the following:

Y N  
  Are you taking birth control pills?  
  Are you pregnant? If yes, # of weeks:   
  Are you nursing?

Y N  
  Do you smoke/use tobacco? How much? \_\_\_\_\_  
 Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (year) _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery (year) _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type) _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis Medication (within last 5 years)
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Pain In Jaw
<input type="checkbox"/>	<input type="checkbox"/>	Pain in joints
<input type="checkbox"/>	<input type="checkbox"/>	Radiation
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetic
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Other:
_____		
_____		

Medications/Supplements:

[Empty box for Medications/Supplements]

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:

[Empty box for description of disease/condition]

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If under 18, Parent or Guardian signature required)

<p><b>For Office Use Only:</b></p> <p>BP: <input type="text"/></p> <p>Heart Rate: <input type="text"/></p>	<p><b>Medical Alerts:</b></p> <p>[Empty box for Medical Alerts]</p>
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