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:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Employer | Your Cell Phone #

Emergency Contact | Emergency Contact #

Who Referred You? | Other Family Members Seen Here? Name:

Pharmacy: | Parent / Guardian

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?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Anemia
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joints
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Bruise Easily
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Heart Attack

Y N	Conditions
☐ ☐	Heart Murmur
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Night Sweats
☐ ☐	Pace Maker
☐ ☐	Pain In Jaw Joints
☐ ☐	Pneumocystitis
☐ ☐	Pre-Med Required
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems
☐ ☐	Stroke

Y N	Conditions
☐ ☐	Taken Fen-Phen
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No