PATIENT MEDICAL HISTORY

Date: _____

Date of your last dental visit? _____

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 defect
__Y__N Congestive heart failure
__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 murmur
__Y__N Heart surgery
__Y__N Hemophilia
__Y__N Hepatitis A
__Y__N High blood pressure
__Y__N HIV/AIDS
__Y__N Joint replacement
__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 Rheumatic fever
__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
__Y__N Iodine

Medications

Please list all surgery types and dates:

Do you have any other conditions not listed above or are you under the care of a physician for a reason not mentioned above? __Y __N
If yes, please explain.

Signature: _____ Date: _____
(If under 18, parent or guardian signature required)