

PATIENT MEDICAL HISTORY

Patient's Name: (please print)

Today's Date:

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Patient's Address:

Email address (optional):

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City, State, ZIP:

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Home / Cell Phone:

Work Phone:

Birthdate:

Marital Status:

Social Security No:

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Physician's Name:

Date of last visit:

Physician Phone:

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Pharmacy of Choice:

Pharmacy Phone:

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If female, please answer the following:

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, # of weeks: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Please answer the following:

	Y	N
Do you smoke, chew, or use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much per day? _____		
For office use only: Blood pressure _____ Heart rate: _____		

Y	N	CONDITIONS	Y	N	CONDITIONS	Y	N	CONDITIONS
		Abnormal Bleeding			Emphysema			Mitral Valve Prolapse
		Alcohol Abuse			Epilepsy			Pacemaker
		Allergies			Fainting Spells			Pneumocystitis
		Anemia			Fever Blisters			Psychiatric Problems
		Angina Pectoris			Frequent Headaches			Radiation Therapy
		Arthritis			Glaucoma			Rheumatic Fever
		Artificial Bones			Hay Fever			Seizures
		Artificial Heart Valve			Heart Attack			Shingles
		Asthma			Heart Surgery			Sickle Cell Disease
		Blood Transfusion			Hemophilia			Sinus Problems
		Cancer-Chemotherapy			Hepatitis A or C			Stroke
		Colitis			Hepatitis B			Thyroid Problems
		Congenital Heart Defect			High Blood Pressure			Tuberculosis
		Cosmetic Surgery			HIV+ AIDS			Ulcers
		Diabetes			Kidney Problems			Venereal Disease
		Difficulty Breathing			Liver Disease			Yellow Jaundice
		Drug Abuse			Low Blood Pressure			

Y	N	ALLERGIES
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline
		Other: _____

Please list any medications you are taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been told to premedicate with antibiotics before dental treatment? No ___ Yes ___ (For what condition _____)

Are you aware of any other disease, condition, or problem that is not covered above? If yes, please describe:

The above information is true to the best of my knowledge.

Signature _____

Date: _____