

## PATIENT MEDICAL HISTORY

Patient's Name:				For Office Use Only ID: <input style="width: 50px;" type="text"/>	
Address:				Today's Date:	Date of Last Visit:
City State Zip:				Email:	
Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:
Primary Dental Guarantor:			Home Phone:	Work Phone:	Cell Phone:
Secondary Dental Guarantor:			Home Phone:	Work Phone:	Cell Phone:
Physician Name:			Physician Phone:		
Pharmacy:			Pharmacy Phone:		

For Office Use Only

Medical Alerts:

Sex:	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 Yes, # of weeks <input style="width: 20px;" type="text"/> <input type="checkbox"/> <input type="checkbox"/> Are you nursing?	Please answer the following: Y N <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco? Height: <input style="width: 40px;" type="text"/> For Office Use Only BP <input style="width: 40px;" type="text"/> Heart Rate: <input style="width: 40px;" type="text"/> Weight: <input style="width: 40px;" type="text"/>
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<table style="width: 100%; border-collapse: collapse;"> <tr><th style="text-align: left;">Y N</th><th style="text-align: left;">Conditions</th></tr> <tr><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td>Anginal/Chest Pain</td></tr> <tr><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td>Artificial Joints</td></tr> <tr><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/></td><td>Cancer- Chemotherapy</td></tr> <tr><td><input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> <tr><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td>Difficulty Breathing</td></tr> <tr><td><input type="checkbox"/></td><td>Drug Abuse</td></tr> <tr><td><input type="checkbox"/></td><td>Emphysema</td></tr> <tr><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td>Fainting Spells</td></tr> <tr><td><input type="checkbox"/></td><td>Fever Blisters</td></tr> <tr><td><input type="checkbox"/></td><td>Frequent Headaches</td></tr> <tr><td><input type="checkbox"/></td><td>Glaucoma</td></tr> </table>	Y N	Conditions	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Anginal/Chest Pain	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Cancer- Chemotherapy	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Glaucoma	<table style="width: 100%; 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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)