PATIENT MEDICAL HISTORY

Name ____ Nickname ____________________ Date:________________

Address ____ Home # ____

City ________________________ Zip Code___________ Work# ____

SSN# ____ Cell # ____

Date of Birth ____ Male ______ Female ______ Marital Status _____________

Emergency Contact's Name ________________________ Contact's Phone # ________________________________

Employer ____ Your Occupation ________________________________

Spouse's Name ________________________________ Date of Birth ______________ SS# ____________________

Spouse's Employer ______________________________ Spouse's Occupation ______________________________

Do you want to receive appt. reminders via text/email? ____

Referred By ____ Email____

Physician's Phone Number ________________________ Dental Insurance __________________________________

Physician's Name ________________________________ Date of Last Dental Visit ____________________________

Preferred Pharmacy ______________________________ Pharmacy Phone Number ___________________________

Please check yes (Y) or no (N) to the appropriate question:

Y	N		Y	N		Y	N	
☐	☐	Angina (chest pains)	☐	☐	Asthma/Emphysema	☐	☐	Thyroid Problems
☐	☐	Heart Attack/Stroke (yr ____)	☐	☐	Tuberculosis	☐	☐	Pregnant
☐	☐	Heart Murmur	☐	☐	Epilepsy/Seizures			**Allergies?**
☐	☐	Mitral Valve Prolapse	☐	☐	Psychiatric Care	☐	☐	Aspirin
☐	☐	Pacemaker/Defibrillator	☐	☐	Venereal Disease	☐	☐	Codeine
☐	☐	High/Low Blood Pressure	☐	☐	HIV/AIDS	☐	☐	Dental Anesthetics
☐	☐	Rheumatic/Scarlet Fever	☐	☐	Immune Deficiency	☐	☐	Erythromycin
☐	☐	Shunt Place	☐	☐	Tumor/Malignancy	☐	☐	Penicillin
☐	☐	Orthopedic Surgery (yr.______)	☐	☐	Radiation/Chemotherapy	☐	☐	Tetracycline
☐	☐	Hip/Knee/Joint Replacement	☐	☐	Tobacco Use ______ pks/day	☐	☐	Sulfa
☐	☐	Bleeding Problems	☐	☐	Blood Transfusion	☐	☐	Jewelry
☐	☐	Liver Problems	☐	☐	Drug Abuse	☐	☐	Latex
☐	☐	Hepatitis A/B/C	☐	☐	Frequent Headaches	☐	☐	Metals
☐	☐	Diabetes	☐	☐	Congenital Heart Defect			Other Allergies (please list below):
☐	☐	Taking Insulin	☐	☐	Fainting Spells			
☐	☐	Kidney Problems	☐	☐	Hemophilia			________________________
☐	☐	Organ Transplant	☐	☐	Arthritis			________________________
☐	☐	Respiratory Problems	☐	☐	TMJ Problems			________________________
								________________________

TURN OVER

PATIENT MEDICAL HISTORY

Medications:

Y N

☐ ☐ Are you or have you ever taken Bisphosphonate drugs (used to treat bone loss or prevent osteoporosis or similar conditions)

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered previously? If yes, please describe below…

Notes:

Signature: ____ **Date:** _______________________________

(If Under 18, Parent or Guardian Signature Required)