

PATIENT MEDICAL HISTORY

Please print legibly

Salutation	First Name	Last Name	M.I.
Home Phone ()	Cell Phone ()	Date of Birth	
Work Phone ()	Fax ()	Gender	
Home Address	City/State/Zip		
Employer Name	Occupation		
Employer Address	Social Security Number		
Referring Doctor	Family Dentist		
Family Physician	Family Physician Phone ()		
Guarantor	Date of Last Physical Exam / /		
Home E-mail	Work E-mail		
Insurance Company	Address		
Subscriber's Name	Subscriber's Social Security Number		
Subscriber's DOB	Group #	Relationship	

Yes	No	Don't Know
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1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
2. Has there been any change in your general health within the past year? If yes, please explain.			
3. Are you under the care of a physician for a current problem? If yes, explain.			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Are you taking any medication or drugs? Please list them below.			
6. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications?			
8. Is there any condition concerning your health that the doctor should be told?			
9. Do you wish to speak to the doctor privately about anything?			
10. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
11. Have you ever required a blood transfusion?			
12. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
13. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
14. Are you required to take antibiotics prior to dental treatment?			
15. Women only: are you pregnant, nursing or on birth control pills?			

Initials here

Please list medications you are taking

Do you have or have you had any of the following?

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Heart murmur or prolapsed valve | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Joint prosthesis (hip, knee, etc.) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic fever or rheumatic heart disease | <input type="checkbox"/> Stomach ulcers, colitis |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Hepatitis, jaundice, liver disease |
| <input type="checkbox"/> Cardiovascular disease: heart attack, stroke or bypass | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Fainting spells or seizures |
| <input type="checkbox"/> Blood disorder (e.g. anemia) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Temporomandibular joint problems (TMJ) |
| <input type="checkbox"/> Allergy to latex | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Chest pain, angina | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Swollen ankles, arthritis or joint disease | <input type="checkbox"/> Contagious diseases |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Bronchitis, chronic cough |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Hay fever or sinus problems |
| <input type="checkbox"/> Delay in healing | <input type="checkbox"/> Problems with the immune system |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Difficult breathing or other lung trouble |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chronic fatigue or night sweats |
| <input type="checkbox"/> X-Ray treatment or chemotherapy | <input type="checkbox"/> History of drug abuse |
| <input type="checkbox"/> On a diet | <input type="checkbox"/> Wear contact lenses |
| <input type="checkbox"/> History of alcohol abuse | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Eye disease or glaucoma | <input type="checkbox"/> Gallbladder trouble |
| <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> None of the above |

Initials here

Please list any other conditions not mentioned above		

Yes	No	Don't Know
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16. Are you taking any herbal medicine (i.e., St. John's Wort)?			
17. Have you ever taken the "fen-phen" diet?			
18. Do you have any disease, condition or problem not listed above? Specify.			

Injury:

This visit is related to an accident	YES / NO	Work related:	YES / NO
Date of injury:			
Insurance company handling the claim:			
Claim Number:			

Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Date

Patient Signature (Parent signature if patient is under 18 years of age).