Patient name_____ Today's date_____
Home address_____ Date of birth_____
_____ Home phone_____
Employer's name and address_____ Driver's License #_____
_____ Business Ph_____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Last exam date_____

	YES	NO
1. Are you currently under any medical treatment ?	☐	☐
2, Have you been hospitalized for any surgery or illness?	☐	☐
3.Are you taking any medications including non prescription meds?	☐	☐
If yes, specify_____		
4. Do you use tobacco?	☐	☐
Alcohol?	☐	☐
Cocaine or other drugs?	☐	☐
5. Are you wearing contact lenses?	☐	☐
6. Do you have dental insurance	☐	☐

7.Are you allergic to or have you had any reactions to any drugs? Please specify:
_____
_____

8. Preferred pharmacy_____

9.WOMEN ONLY:	YES	NO
A)Are you pregnant or think you may be pregnant?	☐	☐
B)Are you nursing?	☐	☐
C)Are you taking birth control pills	☐	☐

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10. Please indicate which of the following applies to you. Check only if YES

☐ High blood pressure	☐ Diabetes	☐ Chest pains	☐ Cancer
☐ Heart attack	☐ Heart disease	☐ Easily winded	☐ Angina
☐ Rheumatic fever	☐ Cardiac pacemaker	☐ Artificial Joint	☐ Asthma
☐ Hay fever/Allergies	☐ Recent weight loss	☐ Liver disease	☐ Anemia
☐ Swollen ankles	☐ Heart murmur	☐ Frequently tired	☐ Arthritis
☐ Fainting/Seizures	☐ Tuberculosis	☐ Stomach troubles/ulcers	☐HIV/Aids
☐ Emphysema	☐ Radiation therapy	☐ Kidney diseases	☐ Glaucoma
☐ Respiratory problems	☐ Thyroid problems	☐ Sexually transmitted disease	☐ Stroke
☐ Low blood pressure	☐ Hepatitis/Jaundice	☐ Joint replacement/implant	☐ Leukemia
☐ Autoimmune disease	☐ Epilepsy/convulsions	☐ Heart valve replacement	☐ Other

TODAY I NEED: _____
Emergency contact: Name_____ Phone #_____ Relationship_____

DENTAL HISTORY (Please check only if the answer is yes

☐Earache ☐Difficult extractions ☐Bleeding gums ☐Oral lumps/sores ☐Teeth clenching
☐Swelling ☐Prolonged bleeding ☐Sweet sensitivity ☐Frequent headache ☐Teeth grinding
☐Braces ☐Cold/hot sensitivity ☐Pain in any teeth ☐Jaw popping/clicking
☐ Difficulty opening or closing your jaw

Patient/Parent/Guardian Signature **X**_____ Date_____