PATIENT MEDICAL HISTORY

Patient's name: _____DOB: _____

Physician's name: _____Physician's Phone: _____

Name of Previous Dentist: _____ Last Dental Exam: _____

Please list all medication you are taking:

_____

_____

_____

_____

Allergies:

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Metals
☐	☐	Dental Anesthetics	☐	☐	Penicillin
☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Jewelry	☐	☐	Other_____

_____

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height: _____ Weight: _____

BP: _____ Pulse: _____

If female, please answer the following:

Y	N	
☐	☐	Are you taking birth control?
☐	☐	Are you pregnant? If yes, _____# of weeks.
☐	☐	Are you nursing?

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

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Blood Transfusion	☐	☐	Fainting Spells	☐	☐	Hepatitis A	☐	☐	Radiation Therapy
☐	☐	Alcohol Abuse	☐	☐	Cancer/Chemo	☐	☐	Fever Blisters	☐	☐	Hepatitis B	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Colitis	☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Sickle Cell Disease
☐	☐	Anaphylaxis	☐	☐	Congenital Heart Defect	☐	☐	Glaucoma	☐	☐	Kidney Problems	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Cosmetic Surgery	☐	☐	HIV/AIDS	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Angina Pectoris	☐	☐	Diabetes	☐	☐	Hay Fever	☐	☐	Low Blood Pressure	☐	☐	Thyroid Problems
☐	☐	Arthritis	☐	☐	Difficulty Breathing	☐	☐	Heart Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Artificial Joints	☐	☐	Drug Abuse	☐	☐	Heart Murmur	☐	☐	Pace Maker	☐	☐	Ulcers
☐	☐	Artificial Heart Valves	☐	☐	Emphysema	☐	☐	Heart Surgery	☐	☐	Pneumocycstitis	☐	☐	Venereal Disease
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Hemophilia	☐	☐	Psychiatric Problems	☐	☐	Yellow Jaundice

Do you pre-medicate with antibiotics prior to your dental appointments? ☐ Yes ☐ No

If yes, why?_____ with what?_____

Please list any dental concerns you have:

_____

Please list any medical concerns you have:

_____

I have reviewed the information in this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist and/or his staff.

Patient's signature:_____Date:_____

Guardian's signature if patient under 18