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	
☐	☐	High/Low Blood Pressure	☐	☐	Epilepsy	☐	☐	Aspirin
☐	☐	AIDS/HIV	☐	☐	Fainting/Dizziness	☐	☐	Codeine
☐	☐	Arthritis/Rheumatism/Gout	☐	☐	Headaches (frequent)	☐	☐	Dental Anesthetics
☐	☐	Artificial Joints/Bones	☐	☐	Hepatitis A/B/C	☐	☐	Erythromycin
☐	☐	Asthma	☐	☐	Herpes	☐	☐	Penicillin
☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐	Tetracycline
☐	☐	Chemotherapy	☐	☐	Liver Disease	☐	☐	Sulfa
☐	☐	Diabetes	☐	☐	Nervous Problems	☐	☐	Latex
☐	☐	Asthma/Emphysema	☐	☐	Psychiatric Care	☐	☐	Metals
☐	☐	Glaucoma	☐	☐	Do you Smoke			Other Allergies (please list below):
☐	☐	Radiation Treatment	☐	☐	Do you drink Alcohol			
☐	☐	Shortness of Breath	☐	☐	High Sugar Intake			_____
☐	☐	Sinus Trouble	☐	☐	Pregnant			_____
☐	☐	Stroke	☐	☐	Nursing			_____
☐	☐	Thyroid Problems	☐	☐	TMJ Problems			_____
☐	☐	Tuberculosis	☐	☐	Sleep Apnea			
☐	☐	Tumor/Growth on Head/Neck	☐	☐	CPAP/Appliance Therapy?			
☐	☐	Ulcer						

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)