

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Physician Name: _____ Phone: _____

Pharmacy: _____ Phone: _____

(Women Only) Are you pregnant or suspect that you may be? YES NO If yes, # of weeks? _____

(Women Only) Do you use any birth control medications? YES NO Are you nursing? YES NO

Do you smoke? YES NO Use Snuff? YES NO Use any other forms of tobacco? YES NO

Do you consume alcohol beverages? YES NO If Yes, how often? _____

Do you habitually use controlled substances? YES NO Height _____ Weight _____

ALLERGIES

Y N Aspirin Y N Codeine Y N Dental Anesthetics Y N Erythromycin

Y N Jewelry Y N Latex Y N Metals Y N Penicillin

Y N Tetracycline Other: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following? (Please circle all that apply)

Abnormal Bleeding	Alcohol Abuse	Allergies	Anemia	Angina Pectoris
Arthritis	Artificial bones	Artificial Heart Valve	Asthma	
Blood Transfusion	Blood Disorder	Cancer	Chemotherapy	Chest Pain
Colitis	Congenital Heart	Cosmetic Surgery	Diabetes	
Difficulty Breathing	Dizziness	Drug Abuse	Emphysema	Epilepsy
Fainting Spells	Fever Blisters	Frequent Headaches	Glaucoma	Hay Fever
Heart Attack	Heart Disease	Heart Surgery	Hemophilia	Hepatitis A
Hepatitis B	Hepatitis C	High Blood Pressure	HIV/AIDS	Kidney Problems
Leukemia	Liver Disease	Low Blood Pressure	Lung Problems	
Mitral Valve Prolapse	Pace Maker	Pneumocystitis	Psychiatric Problems	
Radiation Therapy	Rheumatic Fever	Seizures	Shingles	Stroke
Sickle Cell Disease	Sinus Problems	Stomach Problems	Thyroid Problems	
Tuberculosis	Tumor	Ulcers	Venereal Disease	Yellow Jaundice

Please list any additional health concerns you may have that were not listed above: _____

MEDICATIONS: (Please list any medications you are presently taking)

Do you require an antibiotic pre-medication for your dental appointments? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's (or Guardian's) Signature

Date