PATIENT MEDICAL HISTORY						
Patient's Name:					For Office Use Only	
Address:			Today's Date:	Date of Last Visit:	: Date of Med. History	
City State Zip:			Email:			
Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:	
Primary Dental Guar	rantor:		Home Phone:	Work Phone:	Cell Phone:	
Secondary Dental G	uarantor:		Home Phone:	Work Phone:	Cell Phone:	
Physician Name:			Physician Phon	ie:		
Pharmacy:			Pharmacy Phor	Pharmacy Phone:		
For Office Use Onl Medical Alerts:	у					
Medicai Alerts.						
Sex: If female	e please answer the follo	wing:	Please answ	ver the following:		
	Are you taking Birth Control	l Pills?	I I	ou smoke or use tobacco?	? Height:	
	=	If Yes, # of weeks	For Office U			
	Are you nursing?		BP:	Heart Rate:	Weight:	
Y N Condition	19	Y N Condition	ins	Y N Conditions	<u> </u>	
☐ ☐ Abnormal		Glaucoma		Stroke	<u>s</u>	
☐ ☐ Alcohol At		☐ ☐ Hay Feve	er	☐ ☐ Thyroid Pro		
Allergies		☐ ☐ Heart Atta		Tuberculos	sis	
Anemia		Heart Sur		Ulcers	··	
☐ ☐ Angina Pe	ctoris	☐ ☐ Hemophil☐ ☐ Hepatitis		☐ ☐ Venereal ☐ ☐ Yellow Jau		
Artificial B	lones	☐ ☐ Hepatitis		L L IONOW OGG	naice	
	leart Valve		od Pressure			
Asthma	Our vanie	HIV+ AID		Y N Allergies		
				Aspirin		
	☐ ☐ Cancer- Chemotherapy ☐ ☐ Liver Disease			☐ ☐ Codeine		
☐ ☐ Colitis	☐ ☐ Colitis ☐ ☐ Low Blood Press			☐ ☐ Dental Ane	esthetics	
_	-			Erythromyd	oin	
				☐ ☐ Jewelry		
Diabetes Preumocystitis		=	Latex			
Difficulty Breathing Psychiatric Prob			Metals			
□ □ Drug Abuse □ □ Radiation Thera □ □ Emphysema □ □ Rheumatic Feve			Penicillin	_		
	na	Rneumati		Other	e	
☐ ☐ Epilepsy☐ Fainting S	analle.	Shingles				
	pelis					
Fever Blis	ters	☐ ☐ Sickle Ce	ell Disease			

Medications:						
Y N						
$\hfill \square$ Is there any disease, condition, or prob If yes, please describe below	lem that you think this office should know ab	out that is not covered above?				
If yes, please describe below						
Notes:						
Signature:	Date:					