PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth _____

Email Address:_____ Cell Phone_____

Sex: M or F Height: _____ Weight: ____lbs. Physician's Name & PH _____

Medical Conditions: Please circle Yes or No

Abnormal Bleeding	Y or N	Heart Surgery	Y or N	ALLERGIES	
Alcohol Abuse	Y or N	Hemophilia	Y or N	Aspirin	Y or N
Anemia	Y or N	Hepatitis A, B or C	Y or N	Codeine	Y or N
Angina Pectoris	Y or N	HIV+ or AIDS	Y or N	Dental Anesthetics	Y or N
Arthritis	Y or N	High Blood Pressure	Y or N	Penicillin	Y or N
Artificial Joints	Y or N	Kidney Problems	Y or N	Sulfa drugs	Y or N
Artificial Heart Valve	Y or N	Liver Disease	Y or N	Tetracycline	Y or N
Asthma	Y or N	Low Blood Pressure	Y or N	Erythromycin	Y or N
Blood Transfusion	Y or N	Mitral Valve Prolapse	Y or N	Metal Reactions	Y or N
Breathing Problems	Y or N	Pace Maker	Y or N	Latex	Y or N
Cancer	Y or N	Pain in jaw joints	Y or N	Nitrous Oxide	Y or N
Colitis or IBS	Y or N	Psychiatric Conditions	Y or N	Any Foods	Y or N
Congenital Heart defect	Y or N	Radiation Therapy	Y or N		
Cosmetic Surgery	Y or N	Rheumatic Fever	Y or N	Any other allergies not listed:	
Diabetes	Y or N	Seizures	Y or N		
Drug Abuse	Y or N	Sleep Apnea	Y or N		
Emphysema/ COPD	Y or N	Sinus Problems	Y or N		
Epilepsy	Y or N	Stroke	Y or N	**FOR WOMEN ONLY:**	
Fainting Spells	Y or N	Thyroid Problems	Y or N	Are you pregnant Y or N	
Fever Blisters	Y or N	Tuberculosis	Y or N	Are you taking birth control Y or N	
Glaucoma	Y or N	Ulcers	Y or N	Are you Nursing Y or N	
Hay Fever	Y or N	Venereal Disease or STD	Y or N		
Heart Attack	Y or N	Yellow Jaundice	Y or N		
Headaches	Y or N	**Any other Conditions :**			

Please list any medications you are taking at this time: _____

_____

1. Do you feel nervous about dental Treatment? _____
2. Have you ever had a bad experience in a dental office? _____
3. Have you been in the hospital in the last two years?_____
4. Have you been under the care of a doctor recently?_____
5. Are you having pain or discomfort at this time?_____
6. If you answered "Yes" to cancer please explain _____
7. Are you a smoker? _____

The Above information is true and I do hereby and request for myself or the above patient, dental services and/or whatever procedures the doctor may deem necessary.

Patient or Guardian Signature: _____ Date _____

OFFICE USE ONLY: Medical alerts Summary