

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address: Today's Date: Date of Last Visit: Date of Med. History:

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City State Zip: Email:

San Antonio, TX	
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Home Phone: Work Phone: Birth Date: Social Security No.: Marital Status:

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Primary Dental Guarantor: Home Phone: Work Phone:

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Secondary Dental Guarantor: Home Phone: Work Phone:

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Physician Name: Physician Phone:

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Pharmacy: Pharmacy Phone:

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For Office Use Only

Medical Alerts:

Sex: Male Female **If female please answer the following:**

Unknown	Y N		
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Are you taking Birth Control Pills?	
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Are you pregnant?	If Yes, # of weeks <input style="width: 30px;" type="text"/>
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Are you nursing?	

Please answer the following:

Y N		
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Do you smoke or use tobacco?	Height: <input style="width: 60px;" type="text"/>
For Office Use Only		Weight: <input style="width: 60px;" type="text"/>
BP: <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	Heart Rate: <input style="width: 60px;" type="text"/>	

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Sinus Prob
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily
<input type="checkbox"/>	<input type="checkbox"/>	Cancer- Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Paget Disease
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Shingles

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease

Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
Other		

Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)