

Medical History Form

Date _____

Patient Information:

Patient's Name _____
Last First Middle
Social Security Number _____ Sex M F Date of Birth _____ Age _____

If Patient is a Minor, give Parent or Guardian's Name _____

Responsible Party Information:

Last Name _____ First _____ Middle _____ Marital Status: _____
Address _____ City _____ State _____ Zip _____
Social Security Number _____ Home Phone _____ Work Phone _____
Date of Birth _____ Relationship to Patient _____
Occupation _____ Employer _____ No. of years Employed _____
Name/Address/Phone No. of nearest relative not living with you: _____

Reason for today's dental visit _____

Date of last dental visit: _____ Reason _____

Have you ever had an experience in a dental office which you would like to tell us about? YES / NO. If yes, please explain:

Are you apprehensive about dental treatment?	YES	NO	Are your teeth sensitive to hot, cold, sweets, pressure?	YES	NO
Do your gums bleed, feel tender or irritated?	YES	NO	Do you have discolored teeth that bother you?	YES	NO
Are you seeing a physician?	YES	NO	Are you happy with the appearance of your teeth?	YES	NO

If so, what is the condition being treated?

The Name & Address of your physician(s): _____

What medication are you taking now? _____

If female, are you pregnant? YES NO. If yes, how long? _____

How did you hear about us? Please circle below:

Yellow Pages	Friend/Relative	Radio AD.	Sign/Flyer	News Paper
Health Fair/Screening	Employee	Employer	Other (Specify)	_____

Circle any of the following which you have had or have at present:

Anemia	Asthma	Arthritis	Blood Disease	Bruise Easily
Chemo (Cancer, Leukemia)	Cortisone Medicine	Diabetes	Emphysema	Epilepsy or Seizure
Glaucoma	Heart Disease	Heart Pacemaker	HIV	Hepatitis
Hemophilia	High Blood Pressure	Heart Murmur	Kidney Trouble	Nervousness
Pain in Jaw Joints	Rheumatism	Rheumatic Fever	Scarlet Fever	Sickle Cell Disease
Thyroid Disease	Tuberculosis	Ulcers	Venereal Disease	

Circle any of the following medications you are allergic to:

Aspirin	Barbiturates, sedatives, or sleeping pills	Local Anesthesia	Codeine or other narcotics
Ladino	Penicillin or other antibiotics	Sulfa Drugs	Other _____

I have answer all the above to the best of my knowledge. If I have any changes to my health or any changes to my medication, I will inform my dentist during my next appointment.

Signature of Patient / Parent / Guardian

-----**FOR OFFICE USE ONLY**-----

MEDICAL HISTORY UPDATED

DR.	Date	DR.	Date	DR.	Date
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