

Patients Name:

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

	State	Zip			
--	-------	-----	--	--	--

City: E-mail:

Work Phone:	

Home Phone: Date of Birth: Soc. Sec. #: Marital Status:

--	--	--	--	--

Primary Dental Guarantor: Home Phone: Work Phone:

--	--	--

Secondary Dental Guarantor: Home Phone: Work Phone:

--	--	--

Physician Name: Physician Phone:

--	--

Pharmacy:

**For Office Use Only**

Medical Alerts:

Sex:		<p><b>Females, please answer the following questions:</b></p> <p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Are you taking birth control pills</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you pregnant?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you nursing?</p>	<p><b>Please answer the following questions:</b></p> <p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?</p>	<p>Height: <input style="width: 50px;" type="text"/></p> <p>Weight: <input style="width: 50px;" type="text"/></p> <p>BP: <input style="width: 50px;" type="text"/></p> <p>HR: <input style="width: 50px;" type="text"/></p>
------	--	---	---	---

<p><b>Yes No CONDITIONS</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Bones</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise Easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer - Chemotherapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug Abuse</p>	<p><b>Yes No CONDITIONS</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV + AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p>	<p><b>Yes No CONDITIONS</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Pace Maker</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>
--	---	--