PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________

Patient Age: ______________________

Patient Prefers To Be Called: ______________________

Is This Patient's 1st Visit To The Dentist? Yes / No

If No, Who Is Patient's Prior Dentist? ______________________

Date Of Last Dental Visit: ______________________

What Is The Reason For Today's Visit? ______________________

Pediatrician Name: ______________________

Pediatrician Phone #: ______________________

Patient Height: ______________________

Patient Weight: ______________________

Does The Patient Have Allergies To Any Food Or Drugs? Yes / No
If Yes, Please Check All That Are Applicable Below:

- Aspirin ______
- Codeine ______
- Dental Aesthetics ______
- Erythromycin ______
- Jewelry ______
- Latex ______
- Metals ______
- Penicillin ______
- Seasonal ______
- Tetracycline ______

Other: ______________________

Does The Patient Smoke Or Use Tobacco? Yes / No

If The Patient Is Female, Please Answer The Following:

- Is she taking birth control pills? Yes / No
- Is she pregnant? Yes / No
- Is she nursing? Yes / No

Other Medical Conditions (Please Check All That Are Applicable Belo

- Down Syndrome ______
- Cerebral Palsy ______
- Learning Problems ______
- Mental Retardation ______

Other: ______________________

Medical Conditions (Please Check All That Are Applicable Below):

- Abnormal Bleeding ______
- Allergies ______
- Anemia ______
- Angina Pectoris ______
- Arthritis ______
- Artificial Bones ______
- Artificial Heart Valve ______
- Asthma ______
- Blood Transfusion ______
- Cancer - Chemotherapy ______
- Colitis ______
- Congenital Heart Defect ______
- Diabetes ______
- Difficulty Breathing ______
- Drug Abuse ______
- Emphysema ______
- Epilepsy ______
- Fainting Spells ______
- Fever Blisters ______
- Hay Fever ______
- Heart Attack ______
- Heart Surgery ______
- Hemophilia ______
- Hepatitis A ______
- Hepatitis B ______
- High Blood Pressure ______
- HIV+ / AIDS ______
- Kidney Problems ______
- Liver Disease ______
- Low Blood Pressure ______
- Mitral Valve Prolapse ______
- Pneumocystitis ______
- Psychiatric Problems ______
- Radiation Therapy ______
- Rheumatic Fever ______
- Seizures ______
- Shingles ______
- Sickle Cell Disease ______
- Sinus Problems ______
- Thyroid Problems ______
- Tuberculosis ______
- Ulcers ______
- Yellow Jaundice ______

Any Other Conditions/Diseases/Problems That We Should Be Aware Of And Is Not Covered Above?
If So, Please Describe Below:

Medications (Please List Any And All That The Patient Is Currently Taking):

X ______________________
Parent/Guardian Signature

______ *Date*

______________________ *Doctor's Signature*

OVER PLEASE

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