

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:

Does The Patient Smoke Or Use Tobacco? Yes / No

If The Patient Is Female, Please Answer The Following:

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

- Is she taking birth control pills?
Is she pregnant?
Is she nursing?

Other: _____

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

- 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:

[Empty box for describing other conditions]

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

[Empty box for listing medications]

X
Parent/Guardian Signature

Date

Doctor's Signature

w):