MEDICAL HISTORY FORM

Personal Information

Name: _____ Date: _____

Address: _____

Phone: Home: _____ Mobile: _____

Gender: M F Date of Birth: _____ Age: _____

Email: _____ SSN: _____

Employer: _____

Referred By: _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Phone: Home: _____ Mobile: _____

Healthcare Provider Information

Do you have a primary care provider? Y N

If yes: Name of Practice/Provider: _____

Phone: _____ Date of Last Exam: _____

Do you currently see any specialist providers? Y N

If yes: Name of Practice/Provider: _____

Phone: _____ Date of Last Exam: _____

Preferred Pharmacy: _____

Medical History Information

Have you ever had surgery? Y N

If yes, please list: Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Serious Illness/Hospitalizations (Last 5 Years):_____

Allergies

Are you allergic to or have you had a reaction to any of the following:

Latex Y N

Local Anesthetic (numbing) Y N

Antibiotics Y N

Sulfa Drugs Y N

Other Medication(s): _____

Food(s): _____

Other: _____

If yes to any, please describe the reaction: _____

Medical Conditions

Please circle any/all that apply:

Cardiovascular Disease

Damaged or Artificial Heart Valves

Congenital Heart Defect

Pacemaker

Low Blood Pressure

High Blood Pressure

Chronic Sinus Congestion

Allergies (Seasonal)

Asthma

Respiratory Conditions (Emphysema, COPD)

Epilepsy or Other Neurological Disorder

Sexually Transmitted Disease

Liver Disease (Hepatitis, Cirrhosis)

Kidney Disease

AIDS/HIV

Thyroid Condition (HYPO/HYPER)

Arthritis

Tuberculosis or Positive TB Test

Anemia

Stomach Condition (GERD, Ulcer)

Osteoporosis

Pregnant or Breastfeeding

Frequent Shortness of Breath

Chest Pain Upon Exertion

Autoimmune Disease: _____

Other Immune Conditions: _____

Mental Health Disorder: _____

Diabetes (If yes, most recent blood sugar and A1C: _____)

Joint Replacement (If yes, which joint: _____ Date: _____)

History of Cancer (Type: _____, Status: _____)

Other: _____

Medications

Please list any and all medications you are currently taking:

Medication	Condition Used to Treat	How Much/Often

**Please use the back of this page to list any additional medications.*

Dental History

Have you ever had an adverse reaction during or immediately following dental treatment? Y N

If so, please describe: _____

Are you currently experiencing any of the following dental issues (circle all that apply):

Toothache

Broken Tooth/Teeth

Sensitivity

Worn Down Teeth

Staining/Yellowing

Painful Area of Soft Tissue

Sore Gums

Bad Breath

Crowded/Crooked Teeth

Chief Dental Complaint: _____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any member of the staff, responsible for any errors or omissions I have made in the completion of this form. I understand that it is my responsibility to alert my dental office of any changes to the information held herein.

Print Patient Name: _____ Date: _____

Signature of Patient: _____

If Patient Under 18, Signature of Parent/Guardian: _____