

**PATIENT MEDICAL HISTORY FORM (pls complete one for each patient)**

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

- Aspirin \_\_\_\_\_
- Codeine \_\_\_\_\_
- Dental Aesthetics \_\_\_\_\_
- Erythromycin \_\_\_\_\_
- Jewelry \_\_\_\_\_
- Latex \_\_\_\_\_
- Metals \_\_\_\_\_
- Penicillin \_\_\_\_\_
- Seasonal \_\_\_\_\_
- Tetracycline \_\_\_\_\_
- Other: \_\_\_\_\_

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 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:

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

X  
\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature