



TODAY'S DATE: \_\_\_\_\_

# MEDICAL HISTORY FORM

Patient's Name: \_\_\_\_\_  
Last First Middle

Social Security Number: \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

If Patient is a Minor, please provide Parent's or Guardian's Name: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Telephone #'s: Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name/Address/Phone of nearest relative not living with you: \_\_\_\_\_

## How did you hear about us? Please check below:

- |  |                                       |                                      |                                    |   |
|--|---------------------------------------|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Yellow Pages    | <input type="checkbox"/> Television   | <input type="checkbox"/> Radio Ad    | <input type="checkbox"/> Billboard | <input type="checkbox"/> Health Fair/Screenings |
| <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Newspaper    | <input type="checkbox"/> Mail Coupon | <input type="checkbox"/> Employer  | <input type="checkbox"/> Sign                   |
| <input type="checkbox"/> Employee        | <input type="checkbox"/> Other: _____ |                                      |                                    |   |

Reason for today's visit: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Have you had an experience in a dental office that you would like to tell us about? YES NO If yes, please explain: \_\_\_\_\_

- |  |  |
|--|--|
| Are you apprehensive about dental treatment? YES NO  | Are your teeth sensitive to hot/cold/sweets/pressure? YES NO |
| Do your gums bleed, feel tender or irritated? YES NO | Do you have discolored teeth that bother you? YES NO         |
| Are you now seeing a physician? YES NO               | Are you happy with the appearance of your teeth? YES NO      |

If so, what is the condition being treated? \_\_\_\_\_

Name/Address/Phone Number of Physician: \_\_\_\_\_

What medications are you taking now? \_\_\_\_\_

If female, are you pregnant? YES NO If yes, how far along? \_\_\_\_\_

## MARK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Heart Pacemaker      | <input type="checkbox"/> Ulcers        | <input type="checkbox"/> Thyroid Disease        | <input type="checkbox"/> Glaucoma      |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Chemo Cancer, Leukemia | <input type="checkbox"/> Pain in Jaw   |
| <input type="checkbox"/> Scarlet Fever    | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> HIV+                   | <input type="checkbox"/> Heart Murmur  |
| <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Kidney Trouble       | <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Cortisone Medicine     | <input type="checkbox"/> Hemophilia    |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Nervousness   | <input type="checkbox"/> Sickle Cell Disease    | <input type="checkbox"/> Hepatitis     |

## MARK ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin or Other Antibiotic | <input type="checkbox"/> Sulfa Drugs                             |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Codeine or Other Narcotics     | <input type="checkbox"/> Barbiturates Sedative or Sleeping Pills |
| <input type="checkbox"/> Iodine            | <input type="checkbox"/> Other _____                    |  |

To the best of my knowledge all the preceding answers are true and correct. If I ever have any changes in my health or if any medicines change, I will inform my dentist at the next appointment.

  X    
Patient/Parent/Guardian Signature

\_\_\_\_\_ Date

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

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Date