MEDICAL HISTORY

Patient Information:

Patient's Name:_____

Last **First** **Middle Initial**

Sex: ☐ Male ☐ Female Date of Birth: ____/____/____ **Age:** _____

Address: _____ City: _____State: _____ Zip Code: _____

Home Phone: _____ Cellular Phone: _____

Mark any medical conditions you had or have at the present time: ☐ **NO MEDICAL CONDITIONS**

☐ Heart Disease	☐Heart Pacemaker	☐Ulcers	☐Thyroid Disease	☐Glaucoma
☐ High Blood Pressure	☐Diabetes	☐Emphysema	☐Chemo (Cancer/Leukemia)	☐Pain in Jaw Joints
☐Blood Disease	☐Scarlet Fever	☐Tuberculosis	☐Arthritis	☐HIV
☐Rheumatic Fever	☐Anemia	☐Asthma	☐Rheumatism	☐Hepatitis
☐Heart Murmur	☐Kidney Trouble	☐Hay Fever	☐Cortisone Medicine	☐Hemophilia
☐ Venereal Disease	☐Epilepsy or Seizures	☐Nervousness	☐Sickle Cell Disease	☐Bruise Easily

☐Other _____

What medications are you taking? _____

_____

The Name and Phone of your Physician: _____

_____

Mark any of the following medications you are allergic to: ☐ **NO KNOWN DRUG ALLERGIES**

☐ Local Anesthetics	☐Penicillin or other antibiotic	☐Sulfa Drugs
☐Aspirin	☐Codeine or other narcotics	☐Barbiturates, Sedatives, or Sleeping Pills
☐ Iodine	☐Other _____	

IF FEMALE ARE YOU PREGNANT? ☐ YES ☐ NO IF **YES** HOW LONG?_____

The Name and Phone of your OB/Gynecologist: _____

_____

Responsible Party Information if Patient is a minor:

Last Name: _____ First: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____

Responsible Party's SS#: _____-____-_____

To the best of my knowledge, all of 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's signature (Parent or Legal Guardian) Date

(For Office Use Only)

MEDICAL HISTORY UPDATED:

_____|_____|_____

Dr. Date Dr. Date Dr. Date