

PATIENT MEDICAL HISTORY

Patient's Name:		Cell Phone Number:		For Office Use Only ID: <input style="width: 50px;" type="text"/>	
Address:		Today's Date:	Date of Last Visit:	Date of Med. History:	
City State Zip:		Email:			
Home Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:	
Primary Dental Guarantor:		Home Phone:	Work Phone:		
Secondary Dental Guarantor:		Home Phone:	Work Phone:		
Physician Name:		Physician Phone:			
Pharmacy:		Pharmacy Phone:			

For Office Use Only Medical Alerts: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

Sex:	If female please answer the following:	Please answer the following:
<input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks <input style="width: 30px;" type="text"/> <input type="checkbox"/> <input type="checkbox"/> Are you nursing?	Y N <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco? Height: <input style="width: 50px;" type="text"/> For Office Use Only BP <input style="width: 50px;" type="text"/> Heart Rate: <input style="width: 50px;" type="text"/> Weight: <input style="width: 50px;" type="text"/>

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