BrightSmiles

PATIENT MEDICAL HISTORY

Name_____Home Phone (____)_____
Last First Middle Initial Work Phone (____)_____
Date of Birth____/____/____ SS#_____Sex: M F Height_____ Weight_____
Closest Relative_____Relationship to Patient_____Phone_____
Family Physician_____Address_____Phone_____
Date of last physical exam_____
Who may we thank for referring you to our office?_____

Please circle if you now have or previously have had any of the following:

Heart Disease	Low Blood Pressure	Psychiatric Treatment	Arthritis
Heart Attack	Bleeding Disorder	Immune System Problems	Anemia
Chest Pain (Angina)	Liver Disease	Fainting	Asthma
Heart Murmur	Hepatitis	Convulsions	Glaucoma
Congenital Heart Defect	Jaundice	Seizures	Thyroid Disease
Rheumatic Fever	Stomach Ulcer	Allergies	Kidney Disease
Rheumatic Heart Disease	Tuberculosis	Diabetes	Cancer
High Blood Pressure	Shortness of Breath	Sinusitis	Artificial Joints
History of TMJ popping pain (Right or Left)		Problems with Healing	

Comments on above:_____
_____
_____

Please circle if you are allergic or have had a reaction to any of the following:

Local Anesthetics	Penicillin or other antibiotics	Iodine	Latex
Barbiturates	Aspirin	Other_____	
Codeine or other narcotics	Sulfa Drugs	Foods_____	

Please list your current medications including non-prescription medications:_____
_____
_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?_____
If so, explain briefly:_____
Date of last dental visit?_____ Previous Dentist?_____
Are you currently under the care of a doctor for any condition? (List)_____
Have you ever used or do you use any street drugs? (List)_____
Have you ever smoked, dipped or chewed tobacco?_____
Do you drink alcoholic beverages?_____
Female—Are you pregnant or nursing?_____Due Date:_____Obstetrician_____
Are you taking birth control pills?_____
Have you had any serious trouble associated with previous dental treatment?_____
Do you have any disease, condition, or problem not listed above that you think I should know about?_____
If so, explain briefly_____
Do you have any medical issues that you wish to discuss privately with your doctor?_____
What kind of problem are you having today?_____

_____
Signature of Patient or Legal Guardian Date

Hygienist:_____ Dentist:_____ Date:_____