PATIENT MEDICAL HISTORY

Patient's Name:

	For Office Use Only ***ID:_____***

Address:	**Today's Date:**	**Date of last Visit:**	**Date of Med. History:**

City, State, Zip:	**Email:**

Home Phone:	**Work Phone:**	**Cell Phone:**	**Birth Date:**	**Social Security No.:**	**Marital Status:**

Responsible Party(Financial):	**Home Phone:**	**Work Phone:**	**Cell Phone:**

Physician Name:	**Physician Phone:**

Sex:

If female, please answer the following:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If Yes, # of Weeks _____
☐ ☐ Are you nursing?

Please answer the following:

Y N
☐ ☐ Do you smoke or use tobacco?

Height: _____

For Office Use Only
BP: _____ Heart Rate: _____

Weight: _____

Y	N	**Conditions**
☐	☐	Abnormal Bleeding
☐	☐	Alcohol or Drug Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Autoimmune Disease
☐	☐	Blood Transfusion
☐	☐	Bone Problems
☐	☐	Cancer
☐	☐	Cardiovascular Disease
☐	☐	Chemo/Radiation
☐	☐	Chest Pain Upon Exertion
☐	☐	Congenital Heart Defect
☐	☐	Congenital Heart Failure
☐	☐	Damage Heart Valves
☐	☐	Diabetes
☐	☐	Eating Disorder
☐	☐	Emphysema

Y	N	**Conditions**
☐	☐	Epilepsy
☐	☐	Fainting Spells/Seizures
☐	☐	Gastrointestinal Disease
☐	☐	Glaucoma
☐	☐	HIV or AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heartburn/Reflux
☐	☐	Hemophilia
☐	☐	Hepatitis/Jaundice
☐	☐	High/Low Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Mental Health Disorder
☐	☐	Mitral Valve Prolapse
☐	☐	Neurological Disorder
☐	☐	Pace Maker
☐	☐	Recurrent Infections
☐	☐	Rheumatic Fever/Heart Disease
☐	☐	Rheumatoid Arthritis
☐	☐	Sexually Transmitted Disease
☐	☐	Sinus Trouble

Y	N	**Conditions**
☐	☐	Stroke
☐	☐	Systemic Lupus Erthematosus
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____
_____
_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below…

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required

WILLIAM HARPER DDS
esthetics & family DENTAL CARE

Medications:

Are you using a CPAP, Sleep Appliance, Medications for Sleeping, or anything else to help you sleep?

YES ☐ **NO** ☐

Is there any disease, condition, or problem that you think this office should know about that is not covered above?

YES ☐ **NO** ☐

If YES, please describe below…

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)