FIRST LIGHT DENTAL OF COASTAL VIRGINIA

Patient Medical History

Patient's Name:

	Office use:

Address:	Today's Date:	Date of Last visit:

City, State, Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	SSN:	Marital Status:

Emergency Contact Relationship:	Emergency Contact 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: _____

Weight: _____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol or drug abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	AFIB
☐	☐	Autoimmune Disease
☐	☐	Blood Transfusion
☐	☐	Bone Problems
☐	☐	Cancer
☐	☐	Cardiovascular Disease
☐	☐	Chemo/Radiation
☐	☐	Chest Pain upon Exertion
☐	☐	Congenital Heart Defect
☐	☐	Congenital Heart Failure
☐	☐	Damaged Heart Valves
☐	☐	Diabetes
☐	☐	Eating Disorder

Y	N	Conditions
☐	☐	Emphysema
☐	☐	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
☐	☐	Sexually Transmitted Disease

Y	N	Conditions
☐	☐	Sinus trouble
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

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

Other: _____

_____

_____

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Medications:	**Reason for medication:**

Surgeries and date:	**Doctor/Hospital performed with/at:**

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:** _____

(Patient signature, If under 18, parent or guardian signature required)