MODERN FAMILY DENTISTRY
Andrew T. Wilson, D.M.D.

PATIENT MEDICAL HISTORY

Patient's Name: | Today's Date

Address: | City | State | Zip Code

Employer: | Email: | Cell Phone:

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

Primary Dental Insurance: | Subscriber | Social Security No.: | Birth Date:

Secondary Dental Insurance: | Subscriber | Social Security No.: | Birth Date:

Physician Name: | Physician Phone:

Pharmacy Name: | Referral Source:

For Office Use Only
Medical Alerts:

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?

For Office Use Only
BP | Heart Rate:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones/Implants
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy/Convulsions
☐	☐	Fainting Spells/Seizures
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A or B
☐	☐	Heart Murmur
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke

Y	N	Conditions
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Other _____

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

Other

_____

_____

_____

Medications Presently Taking:

Y N

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

Medical History Updates:

Date:	**Date:**
Date:	**Date:**
Date:	**Date:**

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)