El Cajon Dental Center

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Patient Medical History Form

Patient Information

- Full Name: _____
- Date of Birth: _____ Age: _____
- Gender: ☐ Male ☐ Female ☐ Other
- Address: _____
- City/State/Zip: _____
- Phone: _____ Alternate Phone: _____
- Email: _____
- Emergency Contact Name & Phone: _____

Medical History

Please check any conditions you have or have had in the past: ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Heart Murmur ☐ Blood Clotting Disorders ☐ Anemia ☐ Diabetes ☐ Thyroid Problems ☐ Asthma ☐ Tuberculosis ☐ Sinus Issues ☐ Sleep Apnea ☐ Hepatitis ☐ HIV/AIDS ☐ Kidney Disease ☐ Liver Disease ☐ Cancer ☐ Seizures ☐ Mental Health Issues ☐ Osteoporosis ☐ Allergies to Medications: _____ ☐ Food or Environmental Allergies: _____ ☐ Other: _____

Medications

Please list all current medications, including dosage:

Drug Allergies

Do you have any drug allergies? Please list:

Surgical History

Please list any surgeries you have had and the dates:

Dental History

- Reason for today's visit: _____
- Previous dental problems/treatments: _____
- Do you have any dental pain currently? ☐ Yes ☐ No
- Do your gums bleed when brushing? ☐ Yes ☐ No
- Do you grind your teeth? ☐ Yes ☐ No

Consent & Acknowledgment

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing correct medical and dental history is essential for safe and effective treatment.

Patient Signature: _____ Date: _____

Doctor/Staff Initials: _____