Medical History for New Patient

Last Name: First Name: Birthdate:
Name of Medical Doctor: ______________________ City/State: ______________
Emergency Contact __________ Phone ________ Relationship ______________

List all medications that you are now taking:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

Tobacco use? If so, what kind and how much? ______________________
Unusual reaction to dental injections? ______________________
Reason for today's visit ______________________ Are you in pain? __________
New patients:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? __________
Do you have BiteWing x-rays that are less than 1 year old? ______________
Name of former dentist ______________________ City/State __________
Date of last cleaning and exam ______________________

Date: