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	☐	☐	Sulfa
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Other

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes Type I / Type II	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Cholestrol
☐	☐	Arthritis	☐	☐	Epilepsy
☐	☐	Surgeries	☐	☐	Any Bisphosphonate Treatment IV / Oral
☐	☐	Hepatitis	☐	☐	Have you been told you need premedication
☐	☐	HIV/AIDS			
☐	☐	Herpes	☐	☐	Tobacco use

New patients:

Unusual reaction to dental injections? _____

Are you in pain? _____

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? _____

Reason for today's visit _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: 06/02/2021