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:

birth control

NOT TAKING ANY MEDICATIONS______

Are you allergic to any of the following? NO KNOWN ALLERGIES_____

Y	N		Y	N	
		Anesthetic			
☐	☐	Penicillin/ Amoxicillin	☐	☐	Iodine
☐	☐	Codeine	☐	☐	Aspirin
☐	☐	Ibuprofen	☐	☐	Sulfa
☐	☐	Latex	☐	☐	Other:________________________

Do you have any of the following medical conditions?

Y	N		Y	N	
		Asthma			
☐	☐	High Cholesterol	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes A1C=	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

Tobacco use? Y N Marijuana use? Y N If yes, what kind and how much?________________________

Unusual reaction to dental injections?________________________

Reason for today's visit________________________ Tooth 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:

Patient Signature:________________________ Doctor Signature:________________________