

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 | |
| <input type="checkbox"/> <input type="checkbox"/> | Anesthetic | <input type="checkbox"/> <input type="checkbox"/> | Iodine |
| <input type="checkbox"/> <input type="checkbox"/> | Aspirin | <input type="checkbox"/> <input type="checkbox"/> | Latex |
| <input type="checkbox"/> <input type="checkbox"/> | Codeine | <input type="checkbox"/> <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> <input type="checkbox"/> | Ibuprofen | <input type="checkbox"/> <input type="checkbox"/> | Sulfa |

Do you have any of the following medical conditions?

- | | | | |
|---|---------------------|---|-----------------------|
| Y N | | Y N | |
| <input type="checkbox"/> <input type="checkbox"/> | Asthma | <input type="checkbox"/> <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> | Bleeding Problems | <input type="checkbox"/> <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> | Cancer | <input type="checkbox"/> <input type="checkbox"/> | Pregnancy |
| <input type="checkbox"/> <input type="checkbox"/> | Diabetes | <input type="checkbox"/> <input type="checkbox"/> | Psychiatric Treatment |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> | Sinus Trouble |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> | Joint Replacement | <input type="checkbox"/> <input type="checkbox"/> | 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: _____