



Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: 1/1/2001
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

- ☐ ☐ Anesthetic
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Ibuprofen

Y N

- ☐ ☐ Iodine
☐ ☐ Latex
☐ ☐ Penicillin
☐ ☐ Sulfa

Do you have any of the following medical conditions?

Y N

- ☐ ☐ Asthma
☐ ☐ Bleeding Problems
☐ ☐ Cancer
☐ ☐ Diabetes
☐ ☐ Heart Murmur
☐ ☐ Heart Trouble
☐ ☐ High Blood Pressure
☐ ☐ Joint Replacement

Y N

- ☐ ☐ Kidney Disease
☐ ☐ Liver Disease
☐ ☐ Pregnancy
☐ ☐ Psychiatric Treatment
☐ ☐ Sinus Trouble
☐ ☐ Stroke
☐ ☐ Ulcers
☐ ☐ 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 _____