Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical _____ City/State _____

Emergency _____ Phon _____ Relationshi _____

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 _____

Unusual reaction to dental _____

Reason for today's _____ Are you in _____

New

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years _____

Do you have BiteWing x-rays that are less than 1 year _____

Name of former _____ City/Stat _____

Date of last cleaning and _____

Date: