Medical History for New Patient

Print

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		Y	N	
☐	☐	Sulfa	☐	☐	Latex	☐	☐	Metals
☐	☐	Penicillin	☐	☐	Aspirin	☐	☐	Erythromycin
☐	☐	Codeine	☐	☐	Anesthetic	☐	☐	Other
☐	☐	Ibuprofen	☐	☐	Iodine			

_____

_____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Joint Replacement	☐	☐	Liver Disease	☐	☐	Acid Reflux/Ulcers
☐	☐	Congenital Heart Defect	☐	☐	Kidney Disease	☐	☐	Fever Blisters
☐	☐	Artificial Heart Valve	☐	☐	Stroke	☐	☐	Asthma
☐	☐	Heart Transplant	☐	☐	Cancer	☐	☐	Frequent Headaches
☐	☐	Heart Murmur	☐	☐	Diabetes	☐	☐	Thyroid Problems
☐	☐	Bleeding Problems	☐	☐	Osteoporosis	☐	☐	Sleep Apnea/Snoring
☐	☐	Hepatitis - Type? _____	☐	☐	Epilepsy/Seizures	☐	☐	High Blood Pressure
☐	☐	HIV+/AIDS	☐	☐	Psychiatric Treatment	☐	☐	Sinus Trouble
☐	☐	Tuberculosis (TB)						
☐	☐	Anything not listed? _____						

Have you ever taken bisphosphonates, such as but not limited to Fosamax and Boniva? (Y/N) _____

Tobacco use? (Y/N) _____ If yes, what kind and how much? _____

Are you Pregnant/Nursing? (Y/N) _____ If yes, explain: _____

Reason for today's visit?

_____

Are you in pain? (Y/N) _____ If so, please describe:

_____

Do you have a Panoramic X-Ray or Full Mouth X-Rays that are less than 5 years old? (Y/N) _____

Do you have BiteWing X-Rays that are less than 1 year old? (Y/N) _____

Name of former dentist: _____ City/State: _____

Reason for leaving:

_____

Date of last cleaning and exam: _____

Today's Date: _____ Signature: _____

Print