

## 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

☐ ☐ 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 \_\_\_\_\_

Date: 08/02/2022