ZUMBRO
FAMILY DENTAL

Medical History for New Patient

Last Name: First Name: Birthdate:

Email Address: _____ Phone/Cell Phone: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take a premedication prior to dental treatment?_____

Are you allergic to any of the following?

Y
- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Other:_____

Y
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ Latex

Do you have any of the following medical conditions?

Y
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes Type I or II
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Joint Replacement

Y
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Psychiatric Treatment
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Ulcers
- ☐ Rheumatic Fever

Y
- ☐ Frequent Headaches
- ☐ Osteoporosis/Osteopenia
- ☐ Radiation Treatment
- ☐ Hepatitis

List any other conditions:_____

Any other significant medical conditions? _____

Recent surgery: _____

Tobacco use? If so, what kind and how much? _____

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:

Patient Signature: _____