# 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 | | Y | |
|---|---|---|---|
| ☐ | Anesthetic | ☐ | Penicillin/Amoxicillin |
| ☐ | Aspirin | ☐ | Sulfa |
| ☐ | Codeine | ☐ | Latex |
| ☐ | Other:________________ | | |

Do you have any of the following medical conditions?

| Y | | Y | | Y | |
|---|---|---|---|---|---|
| ☐ | Asthma | ☐ | Kidney Disease | ☐ | Frequent Headaches |
| ☐ | Bleeding Problems | ☐ | Liver Disease | ☐ | Osteoporosis/Osteopenia |
| ☐ | Cancer | ☐ | Pregnancy | ☐ | Radiation Treatment |
| ☐ | Diabetes Type I or II | ☐ | Psychiatric Treatment | ☐ | Hepatitis |
| ☐ | Heart Murmur | ☐ | Sinus Trouble | | |
| ☐ | Heart Trouble | ☐ | Stroke | | |
| ☐ | High Blood Pressure | ☐ | Ulcers | | |
| ☐ | Joint Replacement | ☐ | Rheumatic Fever | | |

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: ________________