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 take:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____

Are you allergic to anything? ☐Yes ☐No

Please mark whether or not you have the following allergies.

Y	N	
☐	☐	Local Anesthetics
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen, naproxen or NSAIDS
☐	☐	Iodine
☐	☐	Latex
☐	☐	Penicillin or Amoxicillin
☐	☐	Sulfa
☐	☐	Morphine
☐	☐	Keflex or other Cephalosporins
☐	☐	Other Drug Allergies
☐	☐	Other Food or Environmental Allergies

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Kidney Failure or Dialysis
☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Hepatitis
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Attack	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Heart Failure	☐	☐	Rheumatic Heart Disease
☐	☐	Artificial Heart Valves	☐	☐	Sleep Apnea or gasp for air when sleeping
☐	☐	Irregular heartbeat or palpitations	☐	☐	Family or personal problem with anesthesia
☐	☐	COPD or other Lung Disease	☐	☐	Thyroid Disease
☐	☐	Smoke Tobacco	☐	☐	Skin Disease
☐	☐	Smoke Other Drugs	☐	☐	Arthritis
☐	☐	Pacemaker or Defibrillator	☐	☐	Back Problems
☐	☐	Radiation treatment	☐	☐	Psychiatric Treatment
☐	☐	Pregnant Now/ Could Possibly be Pregnant	☐	☐	Other Health Problems

How tall are you? _____ How much do you weigh? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have x-rays available for your visit today? _____

Who referred you to us? Or how did you hear about us? _____

Name of General dentist: _____

<-- Sign

Date: