MEDICAL HISTORY FOR NEW PATIENT

Last Name: _____First Name: _____Birthdate: _____
Name of Medical Doctor: _____ MD's phone #: _____
Emergency Contact: _____Phone: _____Relationship: _____

LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DO YOU REQUIRE PREMEDICATION (Antibiotics) FOR DENTAL TREATMENT?_____
(If you answered YES, please list the premedication):
_____

ALLERGIES:
___Anesthetic ___Idodine ___OTHER (Please list any other allergies)
___Aspirin ___Latex
_____
___Codeine ___Penicillin
___Ibuprofen ___Sulfa

MEDICAL CONDITIONS:
___Asthma ___Kidney Disease ___OTHER Medical Conditions
___Bleeding Problems ___Liver Disease
_____
___Cancer ___Pregnancy
___Diabetes ___Psychiatric Treatment
___Heart Murmur ___Sinus Trouble
___Heart Trouble (Stent/pacemaker/etc.) ___Stroke
___High Blood Pressure ___Ulcers
___Joint Replacement ___Rheumatic Fever

TOBACCO USE?_____

Unusual reaction to dental injections? _____

REASON FOR TODAY'S VISIT: _____
ARE YOU IN PAIN: _____ DATE OF LAST CLEANING + EXAM: _____
DATES OF PREVIOUS X-RAYS (Panoramic, Bitewings, or Full Mouth x-rays): _____
PREVIOUS DENTIST: _____ CITY/STATE: _____