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:

___ Alzheimer's Disease ___ Heart Murmur ___ Rheumatic Fever
___ Asperger Syndrome ___ Heart Trouble (Stent/Pacemaker/Etc.)
___ Asthma ___ High Blood Pressure ___ Sinus Trouble
___ Autism ___ JOINT REPLACEMENT ___ Stroke
___ Bleeding Problems ___ Kidney Disease ___ Thyroid Condition
___ Cancer ___ Liver Disease ___ Ulcers
___ Dementia ___ Pregnancy ___ OTHER Medical Conditions
___ Diabetes ___ Psychiatric Treatment _____
_____

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: _____