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 are now taking:

______ ______
______ ______
______ ______
______ ______
______ ______

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine	☐	☐	Other: If yes, please list
☐	☐	Aspirin	☐	☐	Latex			______
☐	☐	Codeine	☐	☐	Penicillin			______
☐	☐	Ibuprofen	☐	☐	Sulfa			______

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Thyroid Problems
☐	☐	Bleeding Problems: INR:	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes: A1C#______ Glucose# ______	☐	☐	Psychiatric Treatment
☐	☐	Tobacco Use/Alcohol Use (please circle)	☐	☐	Heart Disease
☐	☐	Kidney Disease	☐	☐	Stroke/Heart Attack
☐	☐	High Blood Pressure	☐	☐	Artifical Heart Valves or Stents
☐	☐	Joint Replacement	☐	☐	Hepatitis, TB, HIV/Aids
☐	☐	Sleep Apnea/use CPAP	☐	☐	Other ______
☐	☐	Snoring			

Tobacco use? If so, what kind and how much? ______
Unusual reaction to injections? ______
Reason for today's visit ______ Are you in pain? ______
Have you had an ER visit or been hospitalized in in the last 12 months: YES NO
Have you had a Panoramic x-ray or Full Mouth x-rays within the last 5 years? ______
Have you had BiteWing x-rays within the last 12 months? ______
Name of former dentist ______ City/State ______
Date of last cleaning and exam ______
Have you had the HPV Vaccine? YES NO
Has your medical Dr ever required pre-medication before dental work? YES NO

Date:

Please Sign Here: ______