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Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ Phone _____

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	
☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Metals
☐	☐	Aspirin	☐	☐	Ibuprofen	☐	☐	Penicillin
☐	☐	Clindamycin	☐	☐	Iodine	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Latex	☐	☐	Tetracycline

DO YOU REQUIRE ANTIBIOTIC PREMEDICATION FOR DENTAL TREATMENT Yes

Do you have any of the following medical conditions? (Conditions with an asterisk may require premedication)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Cortisone Therapy	☐	☐	Hemophilia	☐	☐	Radiation Treatment
☐	☐	Acid Reflux	☐	☐	Diabetes	☐	☐	Hepatitis A, B, C	☐	☐	Respiratory Issues
☐	☐	Alcohol/Drug Abuse	☐	☐	Dry Mouth	☐	☐	High Blood Pressure	☐	☐	Rheumatism
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	HIV/AIDS	☐	☐	Sexually Transmitted Disease
☐	☐	Angina Pectoris	☐	☐	Fainting or Dizziness	☐	☐	Jaundice			
☐	☐	Arthritis	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Sickle Cell Disease
☐	☐	Artificial Heart Valve*	☐	☐	Frequent Headache	☐	☐	Liver Disease	☐	☐	Sinus Problems
☐	☐	Artificial Joints*	☐	☐	Glaucoma	☐	☐	Mental Disorders	☐	☐	Sjogrens Syndrome
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Sleep Apnea
☐	☐	Blood Thinners	☐	☐	Heart Disease	☐	☐	Nervousness	☐	☐	Stroke
☐	☐	Blood Transfusion	☐	☐	Congenital Heart Disorder*	☐	☐	Osteoporosis	☐	☐	Surgical Shunt*
☐	☐	Chemotherapy				☐	☐	Pace Maker	☐	☐	Thyroid Problems
☐	☐	Cold Sores	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Ulcers
			☐	☐	Heart Surgery*						

Y N

☐☐ Do you have any health problems that were not listed above? If yes, please explain below:

_____

☐☐ Are you now under the care of a medical specialist?

Cardiologist: _____ Phone: _____

Orthopedist _____ Phone: _____

Other Specialist _____ Phone: _____

☐☐ Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain: _____

☐☐ Do you use tobacco? Please explain: _____

WOMEN: Are You Pregnant Y ☐ N ☐ Trying to get pregnant Y ☐ N ☐ Nursing Y ☐ N ☐ Taking Oral Contraceptives Y ☐ N ☐

To the best of my knowledge, all of the preceeding answers are correct. If I have any changes in my health status or, if my medications change, I will inform the dentist and the staff at the next appointment without fail.

Date: _____

Signature