Eastview Dental Professionals

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?

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

DO YOU REQUIRE ANTIBIOTIC PREMEDICATION FOR DENTAL TREATMENT No

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

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

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