Medical History

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	☐	☐	Environmental/Food
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Other
☐	☐	Codeine	☐	☐	Penicillin			
☐	☐	Ibuprofen	☐	☐	Sulfa			

Do you have any of the following medical conditions and/or been treated for them?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Hepatitis
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Thyroid
☐	☐	Arthritis	☐	☐	Sinus Trouble
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Seizures
☐	☐	Joint Replacement	☐	☐	Gastrointestinal Disease
☐	☐	Bone Disease	☐	☐	Sleep Disorder
☐	☐	Pyschiatric Disease	☐	☐	Other

Alcohol use? How many drinks per week?

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: