Medical History for New Patient

Last Name: ____________ First Name: ____________ Birthdate: ____________

Emergency Contact: ____________ Phone ____________ Relationship: ____________

List all medications that you are now taking:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Are you allergic, or have you reacted adversely, to any of the following?

☐ Local anesthetic ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Metal ☐ Aspirin, acetaminophen, or ibuprofen

☐ Codeine and narcotics ☐ Barbiturates and sedatives ☐ Other ____________

Have you ever taken Fosamax, Boniva, Actonel, or other bisphosphonates? ☐ Y ☐ N

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

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	AIDS/HIV+	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	Joint replacement
☐	☐	Anemia or bleeding problems	☐	☐	Kidney disease or dialysis
☐	☐	Allergies or sinus problems	☐	☐	Liver disease or hepatitis
☐	☐	Artificial heart valve	☐	☐	Ulcers or stomach/intestinal disease
☐	☐	Heart pacemaker	☐	☐	Psychiatric treatment, depression, anxiety
☐	☐	Chest pain	☐	☐	Seizures, epilepsy
☐	☐	Congenital heart defects	☐	☐	Glaucoma
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis
☐	☐	Heart attack/failure	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Alcohol/drug abuse
☐	☐	Heart Trouble, Explain:	☐	☐	Radiation therapy to head and neck
☐	☐	Cancer. Explain:	☐	☐	Herpes or other STDs
☐	☐	Diabetes	☐	☐	Other medical conditions: ____________

Females only: Check all that apply.

☐ Pregnant, expected delivery date: ____________ ☐ Nursing ☐ Taking oral contraceptives

Reason for today's visit ____________ Are you in pain? ____________

Name of former dentist ____________ City/State ____________

Date of last cleaning and exam: ____________ Do your gums bleed? ☐ Y ☐ N

List any problems with previous dental treatment ____________

Do you grind or clench your teeth? ☐ Y ☐ N Do you have any jaw symptoms? ☐ Y ☐ N

Do you have dry mouth? ☐ Y ☐ N

I have answered all of the above to the best of my knowledge and will notify the dentist or staff of any changes in medical history.

Signature X ____________ Date: