Medical History

First Name: Last 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	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	ADD/ADHD	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	HIV/AIDS
☐	☐	Autism	☐	☐	Hospitalizations
☐	☐	Bleeding Problems	☐	☐	Joint Replacement
☐	☐	Cancer	☐	☐	Kidney Disease
☐	☐	Cerebral palsey	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Pregnancy
☐	☐	Down Syndrome	☐	☐	Psychiatric Treatment
☐	☐	Epilepsy	☐	☐	Rheumatic Fever
☐	☐	Fetal Alcohol Syndrome	☐	☐	Sinus Trouble
☐	☐	Headaches	☐	☐	Stroke
☐	☐	Heart Murmur	☐	☐	Surgeries
☐	☐	Heart Trouble	☐	☐	Ulcers

Please list any medical conditions, surgeries, or allergies that were not included above:

_____

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

Unusual reaction to dental injections? _____

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

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: