Medical History for New Patient

Last Name: First Name: Birhdate:

List all medications that you are now taking:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Premedications required by physician

☐ ☐

Are you allergic to any of the following?

- ☐ ☐ Anesthetic
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Ibuprofen
- ☐ ☐ Iodine
- ☐ ☐ Latex
- ☐ ☐ Penicillin
- ☐ ☐ Sulfa

Do you have any other allergy not listed above?

Do you have any of the following medical conditions?

- ☐ ☐ Asthma
- ☐ ☐ Bleeding Problems
- ☐ ☐ Cancer/ Tumor
- ☐ ☐ Diabetes
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Trouble
- ☐ ☐ High Blood Pressure
- ☐ ☐ Joint Replacement/ Artifitial Joints
- ☐ ☐ HIV-positive/ AIDS
- ☐ ☐ Hepatitis, jaundice, or liver problem
- ☐ ☐ Herpes or STD
- ☐ ☐ Thyroid Problems
- ☐ ☐ Pacemaker
- ☐ ☐ Kidney Disease/ Bladder Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Pregnancy
- ☐ ☐ Psychiatric Treatment
- ☐ ☐ Sinus Trouble
- ☐ ☐ Stroke
- ☐ ☐ Ulcers
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Tuberculosis
- ☐ ☐ Osteoporosis
- ☐ ☐ Epilepsy, seizures, fainting spells
- ☐ ☐ Arthritis

Do you have any disease, condition, or problem not listed above that you feel we should know about?

Do you drink alcohol? If so, how much?

Tobacco use? If so, what kind and how

Are you taking contraceptive or other

Reason for today's Are you in

New

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

Do you have BiteWing x-rays that are less than 1 year NO

Name of former City/Stat

Date of last cleaning and