



MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Check all medications that you are now taking/add any additional ones. Please cross off any medication you are no longer taking.

- | | |
|--|---|
| <p>1. <input type="checkbox"/> _____</p> <p>2. <input type="checkbox"/> _____</p> <p>3. <input type="checkbox"/> _____</p> <p>4. <input type="checkbox"/> _____</p> <p>5. <input type="checkbox"/> _____</p> | <p>6. <input type="checkbox"/> _____</p> <p>7. <input type="checkbox"/> _____</p> <p>8. <input type="checkbox"/> _____</p> <p>9. <input type="checkbox"/> _____</p> <p>10. <input type="checkbox"/> _____</p> |
|--|---|

Are you allergic to any of the following?

Y N

- Anesthetic
- Aspirin
- Codeine
- Ibuprofen

Other allergies not listed above: _____

Y N

- Iodine
- Latex
- Penicillin
- Sulfa

Do you have any of the following medical conditions?

Y N

- Anemia
- Asthma
- Artificial Bones
- Arthritis
- Artificial Heart Valve
- Bleeding Problems
- Blood Transfusion
- Bruises Easily
- Cancer/Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse

Y N

- Emphysema
- Epilepsy
- Fainting Spells
- Hemophilia
- Heart Trouble
- Hepatitis
- HIV/Aids
- Heart Attack
- High Blood Pressure
- Joint Replacement
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse

Y N

- Pace Maker
- Pregnancy
- Psychiatric Treatment
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sinus Trouble
- Sleep Apnea
- Stroke
- Thyroid Problems
- Tuberculosis
- Yellow Jaundice
- Ulcers

Are you taking Birth Control _____

Other conditions not listed above:

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

Unusual reaction to dental injections? _____

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

Patient/Guardian Signature

Date: _____

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: _____