**Medical History for New Patient**

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

Anesthetic Aspirin Codeine Ibuprofen

Y N

Iodine Latex Penicillin Sulfa

|  |  |
| --- | --- |
| Do you have any of the following medical conditions? |  |
| Y NAsthma | Y | N | Kidney Disease |
| Bleeding Problems |  |  | Liver Disease |
| Cancer |  |  | Pregnancy |
| Diabetes |  |  | Psychiatric Treatment |
| Heart Murmur |  |  | Sinus Trouble |
| Heart Trouble |  |  | Stroke |
| High Blood Pressure |  |  | Ulcers |
| Joint Replacement |  |  | Rheumatic Fever |
| HIV |  |  | Hep C |
| Hep B |  |  |  |

Other Medical Conditions

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:

Name of former dentist City/State

Date of last cleaning and exam

Signature: Date: