MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:
EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Joint Replacement	☐	☐	Ulcers

Other conditions not listed 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: _____

Patient/Guardian Signature
Date: 03/28/2025

_____