# 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: _____

_____