Medical History for New Patient

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications that you take:
If you take no medications type "None"

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____

Please mark whether or not you have the following allergies.

Y	N	
☐	☐	Local Anesthetics
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen, naproxen or NSAIDS
☐	☐	Iodine
☐	☐	Latex
☐	☐	Penicillin or Amoxicillin
☐	☐	Sulfa
☐	☐	Morphine
☐	☐	Keflex or other Cephalosporins
☐	☐	Other Drug Allergies
☐	☐	Other Food or Environmental Allergies

Do you have any of the following medical conditions? YOU MUST CHECK Y/N FOR ALL OF THE FOLLOWING

Y	N		Y	N	
☐	☐	Abnormal Bleeding / Bruising	☐	☐	High / Low Blood Pressure
☐	☐	Anemia	☐	☐	HIV / AIDS
☐	☐	Artificial Joints / Valves	☐	☐	Hospitalizations / Surgeries
☐	☐	Arthritis	☐	☐	Kidney Disease, Kidney Failure, or Dialysis
☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Blood Disease	☐	☐	Lung Disease / COPD
☐	☐	Cancer	☐	☐	Mental Disorder
☐	☐	Congenital Heart Defect	☐	☐	Nervous Disorder
☐	☐	Diabetes	☐	☐	Pregnancy
☐	☐	Dizziness	☐	☐	Psychatric Treatment
☐	☐	Drug / Alcohol Use	☐	☐	Radiation / Chemotherapy
☐	☐	Emphysema	☐	☐	Respiratory Problems
☐	☐	Epilepsy / Seizures / Fainting	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Fever Blisters / Herpes	☐	☐	Sexually Transmitted Disease (STD)
☐	☐	Glaucoma	☐	☐	Shingles
☐	☐	Headache - Severe / Frequent	☐	☐	Sickle Cell Disease / Trait
☐	☐	Head Injuries	☐	☐	Sinus Problems
☐	☐	Heart Attack	☐	☐	Smoke
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Heart Murmur	☐	☐	Thyroid Problems
☐	☐	Heart Surgery / Pacemaker	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis	☐	☐	Ulcers / Colitis
☐	☐	Hemophilia	☐	☐	Other

How tall are you? _____ How much do you weigh? _____

Unusual reaction to dental injections? _____

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

Do you have x-rays available for your visit today? _____

Who referred you to us? Or how did you hear about us? _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.

Date:

Signature: _____