Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications or drugs you are now taking:

☐None

List all medications or drugs you are allergic to:

☐None

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen:

☐ None
☐ AIDS
☐ Anemia
☐ Anxiety Disorder
☐ Arthritis
☐ Artificial Heart Valves
☐ Asthma
☐ Bisphosphonates
☐ Cancer Tumor
☐ Epilepsy / Seizures
☐ Gastro-esophageal reflux disease
☐ Glaucoma
☐ Heart Murmur
☐ Heart Surgery
☐ Heart Trouble
☐ High Blood Pressure
☐ HIV Positive
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Psychiatric Treatment
☐ Pacemaker
☐ Rheumatic
☐ Sensitivity to Latex or Metals
☐ Sexually Transmitted Diseases
☐ Sinus Trouble
☐ Stroke
☐ Hepatitis
☐ Tuberculosis
☐ Diabetes

Have you been hospitalized in the past year? Yes ☐ No ☐

If Yes, explain _____

Has there been any change in your general health in the past year? Yes ☐ No ☐

If Yes, explain _____

Are you experiencing any unresolved stress? Yes ☐ No ☐

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 _____

Date: 05/01/2014