

Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

List all medications that you are now taking:

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following?

Y N

Anesthetic

Aspirin

Codeine

Ibuprofen

Food/Food Dye

Y N

Tylenol

Latex

Penicillin

Sulfa

Other

If yes, please explain allergic reaction:

Do you have any of the following medical conditions?

Y N

Asthma

Bleeding Problems

Cancer

Diabetes

Heart Murmur

Heart Condition

High Blood Pressure

Joint Replacement

Heart Attack/Failure

Pacemaker

Hepatitis

Chron's Disease

Y N

Kidney Disease

Liver Disease

Lung Disease

Psychiatric Treatment

Sinus Trouble

Stroke

Ulcers

Rheumatic Fever

Auto-immune Disorder

Arthritis

Recent Weight Loss/Gain

Low Blood Pressure

Y N

Blood Disorder

Alzheimer's

Dementia

Heart Valve

Osteoporosis

Thyroid Disease

Parathyroid Disease

Swelling of Limbs

Glaucoma

History of Drug Addiction

Hypoglycemia

Other

Tobacco use? If so, what kind and how _____

Unusual reaction to dental injections? _____

Reason for today's _____

Are you in _____

Y N Women Only:

Are you Pregnant or trying to get Pregnant?

Due Date if applicable:

Breastfeeding?

Taking Birth Control?

Signature: _____

Date: _____