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		Y	N	
☐	☐	Anesthetic	☐	☐	Tylenol
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa
☐	☐	Food/Food Dye	☐	☐	Other

If yes, please explain allergic reaction:

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐	Blood Disorder
☐	☐	Bleeding Problems	☐	☐	Liver Disease	☐	☐	Alzheimer's
☐	☐	Cancer	☐	☐	Lung Disease	☐	☐	Dementia
☐	☐	Diabetes	☐	☐	Psychiatric Treatment	☐	☐	Heart Valve
☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐	Osteoporosis
☐	☐	Heart Condition	☐	☐	Stroke	☐	☐	Thyroid Disease
☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐	Parathyroid Disease
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever	☐	☐	Swelling of Limbs
☐	☐	Heart Attack/Failure	☐	☐	Auto-immune Disorder	☐	☐	Glaucoma
☐	☐	Pacemaker	☐	☐	Arthritis	☐	☐	History of Drug Addiction
☐	☐	Hepatitis	☐	☐	Recent Weight Loss/Gain	☐	☐	Hypoglycemia
☐	☐	Chron's Disease	☐	☐	Low Blood Pressure	☐	☐	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: _____