Medical History

Last Name: First Name: Birthdate:

Name of Medical Doctor: ______________________ City/State: ______________________

Emergency Contact ______________ Phone ______________ Relationship ______________

Current Medications

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Are you allergic to any of the following? Other:

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnant Due date: ______________
☐	☐	Diabetes	☐	☐	Blood Thinner
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure			Other:
☐	☐	Joint Replacement			

Tobacco use? If so, what kind and how much?

Unusual reaction to dental injections?

Reason for today's visit Are you in pain?

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

Date of last cleaning and exam

Date: 07/13/2023 Please sign: