Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor:_____PH#_____

Emergency Contact:_____PH#_____ SS#_____

List all medications that you are now taking:

_____

_____

CHECK ALLERGIES: ☐ aspirin ☐ codeine ☐ latex ☐ novacaine ☐ penicillin

☐ if you have any other allergy not listed please list:_____

please circle if you have any of the following medical conditions?

aids
acid reflux
anemia
angioedema
arithiritis
artifical appliance
artificial heart valves
artificial joints
asthma
back problems
blood disease
cancer
cebrebal palsy
chemical dependency
chemotherapy
circulatory problems
cortisone treatments
cough, persistent
cough up blood
crohns
diabetes
epilepsy/ seizures
fainting
glaucoma
gout
headaches
heart murmer
hemophillia
hepatits
high blood pressure
hiv positive
hydrocephalus
jaw pain
kidney disease
liver disease
lupus
mds
mitral valve prolapse
MS
nervous problems
osteoporosis
pacemaker
psychiatric care
radiation treatment
respiratory disease
rheumatic fever
scarlet fever
shortness of breath
skin rash
stroke
stomach problems
swelling of feet or ankles
thyroid problems
tobacco habit
tonsillitis
tuberculosis
ulcer
venereal disease

☐ heart problem , please describe

_____

☐ are you pregnant ? if yes please check box

if you have any other medical conditions or are scheduled for any procedures please describe below

_____

DENTAL HISTORY

PLEASE RATE YOUR SMILE FROM A 1 TO 10:_____

Name of former dentist:_____PH#_____

Reason for today's visit:_____

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ☐ YES ☐ NO

☐ BAD BREATH
☐ BLEEDING GUMS
☐ CLICKING OR POPPING JAW
☐ FOOD COLLECTION BETWEEN TEETH
☐ GRINDING TEETH
☐ LOOSE TEETH OR BROKEN FILLING
☐ PERIODONTAL TREATMENT
☐ SENSITIVITY TO COLD
☐ SENSITIVITY TO SWEETS
☐ SENSITIVITY WHEN BITING
☐ SORES OR GROWTH IN YOUR MOUTH

IF HAVE YOU EVER HAD A PROSTHESIS (PARTIAL, DENTURE, ETX), HOW LONG AGO:_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health

Signature or legal guardian_____Date_____