Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor: ______________________ City/State: ______________

Pharmacy Preference: ______________________________________

List all medications that you are now taking:

Are you allergic to any of the following?

Y	N	
☐	☐	Anesthetic
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen
☐	☐	Sedatives
☐	☐	Iodine
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Other ______________

Do you have any of the following medical conditions?

Y	N	
☐	☐	Asthma
☐	☐	Abnormal Bleeding
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Angina
☐	☐	AIDS / HIV
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Cardiovascular Disease
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Disease
☐	☐	Anxiety
☐	☐	Osteoporosis
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Pregnancy
☐	☐	Psychiatric Treatment
☐	☐	Hepatitis B / Hepatitis C
☐	☐	Stroke
☐	☐	Ulcers
☐	☐	Arthritis
☐	☐	Autoimmune Disease
☐	☐	Rheumatoid Arthritis
☐	☐	Thyroid Problems
☐	☐	Gastrointestinal Disease
☐	☐	Epilepsy

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? __________

Have you taken or scheduled to begin treatment with an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa, XGeva) for osteoporosis, Paget's disease, multiple myeloma, or metastatic cancer? ______________________________

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