NEW PATIENT - MEDICAL HISTORY FORM

NAME: _____ Date: _____
Name of Medical Doctor: _____ Phone: _____
How did you hear of our practice: _____

Please list any surgeries/serious illnesses that you have had in the past 5 years: _____ _____
_____
_____

Are you currently under the care of a physician: Yes No For what: _____

Medications that you are currently taking, including herbal remedies: _____
_____

Have you ever been told by a previous dentist/physician that you need to pre-medicate prior to dental treatment? Yes No

Have you ever had or do you presently have:

	Yes	No		Yes	No
Heart Attack	☐	☐	**Drug Addiction**	☐	☐
Heart Surgery	☐	☐	**Bleeding Problems**	☐	☐
Heart Pacemaker	☐	☐	**Bruise Easily**	☐	☐
Heart Disease	☐	☐	**Tuberculosis**	☐	☐
Artificial Heart Valve	☐	☐	**Epilepsy or Seizures**	☐	☐
Artificial Joints (knee, Hip, elbow, etc)	☐	☐	**Glaucoma**	☐	☐
Date of replacement _____			**Blood Thinners**	☐	☐
Heart Murmur	☐	☐	**Rheumatic Fever**	☐	☐
Congenital Heart Defect	☐	☐	**Cancer**	☐	☐
Mitral Valve Prolapse	☐	☐	**Type _____**		
High Blood Pressure	☐	☐	**Emphysema**	☐	☐
Stroke	☐	☐	**Asthma**	☐	☐
Diabetes	☐	☐	**Hay Fever**	☐	☐
AIDS or HIV positive	☐	☐	**Sinus Problems**	☐	☐
Hepatitis A B C	☐	☐	**Thyroid Disease**	☐	☐
Kidney Disease	☐	☐	**Ulcers**	☐	☐
Hemophilia	☐	☐	**Osteoporosis**	☐	☐

For Women only:	Yes	No		Yes	No		Yes	No
Are you pregnant	☐	☐	**Nursing:**	☐	☐	**On Birth Control Medication**	☐	☐

Are you allergic or have you reacted adversely to any of the following: Please check either YES or NO.

	Yes	No		Yes	No		Yes	No
Aspirin	☐	☐	**Metals**	☐	☐	**Sulfa drugs**	☐	☐
Tylenol	☐	☐	**Latex (Rubber)**	☐	☐	**Local Anesthetics**	☐	☐
Nut allergy	☐	☐	**Antibiotic allergy**	☐	☐	**Other: _____**		
			Please list _____					

Are you nervous about dental visits: Yes No Why: _____
Date of your last dental exam: _____ Date of last dental xrays: _____

Are your teeth sensitive to hot, cold, sweets, or pressure?	**Yes**	**No**	**Do you wear a Night Guard?**	**Yes**	**No**
Have you ever had orthodontic treatment (braces)?	**Yes**	**No**	**Gums bleed when brushed?**	**Yes**	**No**
Have you been told you have periodontal disease?	**Yes**	**No**	**Do you use tobacco?**	**Yes**	**No**

Is there anything about your smile that you do not like? (*color, shape, gummy smile, straightness, function, etc***)**

_____
_____

I certify that these statements concerning my health are correct to the best of my knowledge and understand that incorrect answers could be affected by dental treatment.

Signature: _____ Date: _____