Medical History

Last Name: First Name: Birthdate:

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa
☐	☐	Amoxicillin _____	☐	☐	Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Alcohol Abuse	☐	☐	Epilepsy	☐	☐	Pace Maker
☐	☐	Anemia	☐	☐	Fainting Spells	☐	☐	Pneumocystitis
☐	☐	Angina Pectoris	☐	☐	Frequent Headaches	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Hay Fever	☐	☐	Psychiatric Problems
☐	☐	Artificial Bones	☐	☐	Heart Attack	☐	☐	Radiation Therapy
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Bleeding Problems	☐	☐	Heart Surgery	☐	☐	Seasonal Allergies
☐	☐	Blood Transfusion	☐	☐	Hemophilia	☐	☐	Seizures
☐	☐	Cancer	☐	☐	Hepatitis A	☐	☐	Shingles
☐	☐	Colitis	☐	☐	Hepatitis B	☐	☐	Sickle Cell Disease
☐	☐	Congenital Heart Defect	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
			☐	☐	HIV - AIDS	☐	☐	Stroke
☐	☐	Cosmetic Surgery	☐	☐	Joint Replacement	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Tuberculosis
☐	☐	Difficulty Breathing	☐	☐	Liver Disease	☐	☐	Ulcers
☐	☐	Drug Abuse	☐	☐	Low Blood Pressure	☐	☐	Yellow Jaundice
☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐	Other: _____

Do you require a premed prior to dental visits? _____

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

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

_____