

New Medical History(Printable Form Without Signature)

Patient Name:

Birth Date:

Date Created:

Is this your first time at our office? If yes, when was your last dental visit? Yes No If yes

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes

Comments: