

McDonald Family Dentistry

Medical History for New Patient

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

Anesthetic

Aspirin

Codeine

Ibuprofen

Y N

Iodine

Latex

Penicillin

Sulfa

Other: _____

Do you have any of the following medical conditions?

Y N

Asthma

Bleeding Problems

Cancer

Diabetes

Heart Murmur

Heart Trouble

High Blood Pressure

Joint Replacement

Y N

Kidney Disease

Liver Disease

Pregnancy

Psychiatric Treatment

Sinus Trouble

Stroke

Ulcers

Rheumatic Fever

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

Unusual reaction to dental injections or anesthesia? _____

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

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date:

Signature: _____