

Medical History

Name: _____

Date: _____

Office use only:

CC: _____
HPI: _____

New patients please answer the following:

Please list medications you are taking (including aspirin): _____

Are you allergic to any medications (including local anesthesia)? _____

Past History:

Do you have a pacemaker? Yes ___ No ___
Have you ever had skin cancer? Yes ___ No ___ If yes, type? _____
Do you have a family history of skin cancer? Yes ___ No ___ If yes, type? _____
Do you have a bleeding disorder? Yes ___ No ___
Do you have a history of: (Check if yes)
X-ray/Ultraviolet treatments Arsenic exposure Immunosuppression/organ transplant
Major illnesses or hospitalizations: _____

Do you have any artificial joints or take antibiotics prior to dental procedures? Yes ___ No ___
Please list any medical conditions that have occurred in your family? _____

Social History:

(Women) Are you Pregnant? Yes ___ No ___
Do you smoke? Yes ___ No ___
Do you have any alcohol or drug problems/addictions? Yes ___ No ___

Review of Systems:

	Do you have any current or past problems with: (If yes, explain)	
Eyes/Glaucoma/Cataracts	Yes ___ No ___	_____
Ears/Nose/Throat/Mouth	Yes ___ No ___	_____
Heart/Hypertension	Yes ___ No ___	_____
Lungs/Asthma	Yes ___ No ___	_____
Stomach/Gastrointestinal	Yes ___ No ___	_____
Kidneys	Yes ___ No ___	_____
Arthritis/Muscles/Joints	Yes ___ No ___	_____
Headaches/Stroke/Seizures	Yes ___ No ___	_____
Anxiety Disorder/Depression	Yes ___ No ___	_____
Thyroid/Diabetes	Yes ___ No ___	_____
Anemia/Bleeding disorder	Yes ___ No ___	_____
Hepatitis/HIV/Tuberculosis	Yes ___ No ___	_____

Reviewed by (MD): _____
Updated by (MD): _____

Date _____
Date _____