Medical History for Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

Medications

_____

_____

_____

_____

_____

Allergies

Y	N			
☐	☐	Penicillin	☐ ☐	Latex
☐	☐	Codeine	☐ ☐	Iodine
☐	☐	Ibuprofen	☐ ☐	Sulfa
			☐ ☐	Aspirin
			☐ ☐	Anesthetic

Sleep Evaluation

	Y	N
Do you breathe through your mouth?	☐	☐
Have you been diagnosed with Obstructive Sleep Apnea?	☐	☐
Do you wear a CPAP?	☐	☐
Have you ever been told that you snore?	☐	☐
Has anyone ever witnessed you stop breathing in your sleep?	☐	☐
Do you ever wake up with headaches?	☐	☐
Do you wake up with dry mouth?	☐	☐

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur or Valve replacement	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

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

Unusual reaction to dental injections? _____

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 _____

Signature: _____ Date: 10/12/2023