MINOCQUA FAMILY DENTAL

Medical History for New Patient

Last Name: First Name: Birthdate:

Guardian/POA: _____

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
☐	☐	Other Allergy _____	☐	☐	Amoxicillin

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	AIDS/HIV Infection	☐	☐	Hepatitis B or C
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Blood Thinners	☐	☐	Liver Disease
☐	☐	Cancer/Radiation	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Osteoporosis	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever
☐	☐	Heart Valve Replacement	☐	☐	Thyroid Disease
☐	☐	Other Condition _____	☐	☐	High Cholesterol
☐	☐	History of Drug Use	☐	☐	Tobacco Use

Any Recent Surgery/Hospitalizations? _____

Date:

_____

Signature