New Patient History

Name (please print)_____

Medical History

Please check the boxes below for any conditions you have ever had.

□ Allergies/Hayfever	□ Heart failure	□ Neurologic disorder
□ Alcohol Abuse	□ Hepatitis	□ Organ transplant
□ Arthritis	□ High blood pressure	□ Psoriasis
□ Asthma	□ Hormonal problems	□ Psychiatric problems
□ Cancer	□ HIV	□ Serious infection
□ Cataracts	□ Kidney disease	□ Skin Cancer
□ Diabetes	□ Leukemia	□ Stomach ulcers
□ Difficulty breathing	□ Liver disease	□ Substance abuse
□ Eczema	□ Lung disease	□ Thyroid disease
□ Gastrointestinal disease	□ Lupus	□ Tuberculosis
□ Glaucoma	□ Lymphoma	□ Venereal disease
□ Heart attack	□ Multiple sclerosis	□ None of the above

Are you instructed to take antibiotics before dental work or surgical procedures? □Yes □No

Do you have any of the following?

Bleeding problem	□Yes	□No	Pacemaker	□Yes	□No
Heart valve problem	□Yes	□No	Defibrillator	□Yes	□No
Endocarditis	□Yes	□No	Keloid Scars	□Yes	□No
Joint replacement	□Yes	□No	Poor wound healing	□Yes	□No
Neurologic shunt	□Yes	□No			

Do you have any other medical problems? _____

_____

Are you allergic to? □ adhesives □ antibiotic ointments □ epinephrine □ iodine □ latex □ lidocaine

Do you have any other allergies to medications? If yes, please list: _____

_____

Please list all prescription and over the counter medications you are taking. _____

_____

_____

Smoking Status: □ every day smoker □ occasional smoker □ former smoker □ never smoked

For Women: Are you? □ pregnant □ nursing □ taking birth control pills □ taking hormones

Pharmacy Name: _____ Pharmacy Phone Number: _____

Patient/Guardian Signature _____ Date _____