SCHULTZ
FAMILY DENTAL

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		Y	N		Y	N	
☐	☐	Local Anesthetic	☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Aspirin	☐	☐	Metal	☐	☐	Sulfa Drugs
☐	☐	Acrylic	☐	☐	Latex			
☐	☐	Other, Please Specify:						

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Epilepsy or Seizures	☐	☐	Nursing
☐	☐	Alzheimer's Disease	☐	☐	Excessive Bleeding	☐	☐	Osteoporosis
☐	☐	Anemia	☐	☐	Frequent Headaches	☐	☐	Parathyroid Disease
☐	☐	Arthritis/Gout	☐	☐	Glaucoma	☐	☐	Pregnant/Trying
☐	☐	Artificial Heart Valve	☐	☐	Heart Attack/Failure	☐	☐	Psychiatric Treatment
☐	☐	Artificial Joint	☐	☐	Heart Murmur	☐	☐	Radiation Treatment
☐	☐	Asthma	☐	☐	Heart Pacemaker	☐	☐	Renal Dialysis
☐	☐	Bisphosphonates Ever Taken?	☐	☐	Heart Trouble/Disease	☐	☐	Rheumatic Fever
☐	☐	Blood Disease	☐	☐	Hepatitis	☐	☐	Sinus Trouble
☐	☐	Bruise Easily	☐	☐	High Blood Pressure	☐	☐	Stomach/ GI Disease
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Stroke
☐	☐	Chemotherapy	☐	☐	Kidney Problems	☐	☐	Thyroid Disease
☐	☐	Cold Sores	☐	☐	Leukemia	☐	☐	Tuberculosis
☐	☐	Congenital Heart Disorder	☐	☐	Liver Disease	☐	☐	Tumors or Growths
☐	☐	Cortisone Medicine	☐	☐	Low Blood Pressure	☐	☐	Ulcers
☐	☐	Diabetes	☐	☐	Lung Disease	☐	☐	Venereal Disease
☐	☐	Other, Please Specify:						

Tobacco use? Y ☐ N ☐ Type, and How Much? _____

Unusual reaction to dental treatment? _____

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: