

# Medical History for New Patient

Last Name: Bresnahan                      First Name: Thomas                      Birthdate: 09/22/1973  
Name of Medical Doctor: \_\_\_\_\_ City/State: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

List all medications that you are now taking:  
EXISTING PATIENTS: Mark any medications that you are no longer taking and add any new ones

<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

Are you allergic to any of the following?

Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Anesthetic	<input type="checkbox"/> <input type="checkbox"/> Iodine
<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Latex
<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Penicillin
<input type="checkbox"/> <input type="checkbox"/> Ibuprofen	<input type="checkbox"/> <input type="checkbox"/> Sulfa

Do you have any of the following medical conditions?

Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> <input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> <input type="checkbox"/> Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Joint Replacement	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever

Chosen Pharmacy Name:

Pharmacy Address:

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 \_\_\_\_\_

Date: 05/19/2023

Signature:

\_\_\_\_\_