Medical History

Last Name: First Name: Birthdate:

Emergency Contact _____ Phone _____ Relationship _____

Mark any medications that you are no longer taking and add any new ones:

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

Please list any allergies, including anesthetic or antibiotics

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Heart Murmur	☐	☐	Osteoporosis
☐	☐	Heart Trouble			
☐	☐	High Blood Pressure			
☐	☐	Joint Replacement			

Explain any "yes" above

Tobacco use? If so, what kind and how much?
Unusual reaction to dental injections?

Date:

Signature