NEW Health

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PATIENT NAME:	DATE OF BIRTH (M/D/Y): / /	HEIGHT:	**OFFICE USE**
		WEIGHT:	BP:
			PULSE:

No ❒ Yes ❒ Are you under a physician's care now? Physician's name and clinic:

Are you interested in receiving medical care from NEW Health Programs Association? Yes ❒ Seeing NEWHP Provider ❒ No ❒
If yes, how do you prefer to be contacted? ❒ Phone: ❒ Email:

No ❒ Yes ❒ Have you ever been hospitalized or had a major operation? *Please explain:*

No ❒ Yes ❒ Have you ever had a serious head or neck injury? *Please explain:*

No ❒ Yes ❒ Are you taking, or have you taken any medications for Osteoporosis? *When:* _____ *How Long:* _____
Are you, or have you taken any of the following? ❒ Fosamax ❒ Boniva ❒ Zometa
Taken: ❒ IV ❒ Oral ❒ Other:

No ❒ Yes ❒ Do you take a blood thinner (Coumadin, Warfarin, Xarelto, etc.)? *Last INR level:* *Date:*

No ❒ Yes ❒ Have you taken an antibiotic before a dental/medical procedure? Please explain:

No ❒ Yes ❒ Do you use tobacco? Type: ❒ Smoking ❒ Chewing ❒ Vaping *How much daily?* *When did you start?*

No ❒ Yes ❒ Do you use marijuana? Type: ❒ Smoke ❒ Edibles ❒ Other: *How much daily?* *When did you start?*

No ❒ Yes ❒ Do you have, or have you had a drug addiction: *What Drug(s):* *When:*

How many carbonated and/or sweetened beverages do you drink a day?

WOMEN: Are you pregnant and/or trying to get pregnant? No ❒ Yes ❒ *Due Date:* *Nursing:* No ❒ Yes ❒

Are you allergic to any of the following? ❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Local Anesthetic ❒ Other:

Do you have, or have you had, any of the following? *(Check the box on the left for all that apply)*

❒ ADHD/ADD	❒ Chemotherapy *When:*	❒ Heart Failure/CHF	❒ PTSD *Cause:*
❒ AIDS/HIV		❒ Heart Trouble/Disease	
❒ Angina/Chest Pain	❒ Chronic Pain	❒ Hepatitis	❒ Radiation Therapy
❒ Arthritis	❒ Cold Sores/Herpes	*Type*: ☐ A ☐ B ☐ C	*Where:* *When:*
❒ Artificial Heart Valve	❒ Congenital Heart Disorder	❒ Hypoglycemia	❒ Renal Dialysis
❒ Artificial Joint(s)	❒ COPD	❒ Infective Endocarditis	❒ Rheumatic Fever
Joints: *When:*	❒ Depression	❒ Irregular Heartbeat	❒ Rheumatism
❒ Asthma	❒ Diabetes Type: ☐ 1 ☐ 2	❒ Kidney Disease	❒ Schizophrenia
☐ *Use Inhaler* ☐ *From Childhood*	*Last A1C Level*:	❒ Liver Disease	❒ Shingles
❒ Autism	❒ Emphysema	❒ Lung Problems:	❒ Sickle Cell Disease
❒ Bipolar Disorder	❒ Epilepsy/Seizures	*Explain:*	❒ Sinus Problems:
❒ Bleeding Disorder	*Type:* *How often:*	❒ Methemoglobinemia	*Explain:*
❒ Blood Disease	❒ Fibromyalgia	❒ Mitral Valve Prolapse	❒ Sleep Apnea
❒ Blood Pressure - HIGH	❒ GERD/Acid Reflux/Ulcers	❒ Other Mental Illness	❒ Stroke
❒ Blood Pressure - LOW	❒ Glaucoma	*Type(s):*	*When:*
❒ Cancer	❒ Headaches/Migraines	❒ Pacemaker	❒ Thyroid Disease
Type:	❒ Heart Attack	❒ Pain in Jaw Joint	❒ Tuberculosis
When:	*When:*	❒ Parathyroid Disease	

Have you ever had any **SERIOUS** illness not listed above? No ❒ Yes ❒ *If yes, please explain:*

LIST MEDICATIONS ON BACK →

NEW Health

PATIENT NAME:	DATE OF BIRTH (M/D/Y): / /
PHARMACY:	

MEDICATIONS

Please list current prescription medications and vitamins/supplements/over-the-counter medications that you are currently taking, including those occasionally used.

Prescription Medications	Vitamins/Supplements/ Over-the-Counter Medications
❒ None	❒ None

To the best of my knowledge, the questions on this form have been accurately answered. I understand that not providing information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office on any changes in medical status.

SIGNATURE OF PATIENT or PARENT/GUARDIAN (if under 18):	DATE:
SIGNATURE OF PROVIDER	DATE: