

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

- | DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO | | YES | NO |
|--|------------|-----------|---|------------|-----------|
| 1. hospitalization for illness or injury _____ | | | 27. arthritis _____ | | |
| 2. an allergic reaction to _____ | | | 28. autoimmune disease _____
(i.e. rheumatoid arthritis, lupus, scleroderma) | | |
| aspirin, ibuprofen, acetaminophen, codeine | | | 29. glaucoma _____ | | |
| penicillin | | | 30. contact lenses _____ | | |
| erythromycin | | | 31. head or neck injuries _____ | | |
| tetracycline | | | 32. epilepsy, convulsions (seizures) _____ | | |
| sulfa | | | 33. neurologic disorders (ADD/ADHD, prion disease) _____ | | |
| local anesthetic | | | 34. viral infections and cold sores _____ | | |
| fluoride | | | 35. any lumps or swelling in the mouth _____ | | |
| metals (nickel, gold, silver, _____) | | | 36. hives, skin rash, hay fever _____ | | |
| latex | | | 37. STI / STD / HPV _____ | | |
| other _____ | | | 38. hepatitis (type ___) _____ | | |
| 3. heart problems, or cardiac stent within the last six months _____ | | | 39. HIV / AIDS _____ | | |
| 4. history of infective endocarditis _____ | | | 40. tumor, abnormal growth _____ | | |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | | | 41. radiation therapy _____ | | |
| 6. pacemaker or implantable defibrillator _____ | | | 42. chemotherapy, immunosuppressive medication _____ | | |
| 7. orthopedic implant (joint replacement) _____ | | | 43. emotional difficulties _____ | | |
| 8. rheumatic or scarlet fever _____ | | | 44. psychiatric treatment _____ | | |
| 9. high or low blood pressure _____ | | | 45. antidepressant medication _____ | | |
| 10. a stroke (taking blood thinners) _____ | | | 46. alcohol / recreational drug use _____ | | |
| 11. anemia or other blood disorder _____ | | | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | | | ARE YOU: | | |
| 13. emphysema, shortness of breath, sarcoidosis _____ | | | 47. presently being treated for any other illness _____ | | |
| 14. tuberculosis, measles, chicken pox _____ | | | 48. aware of a change in your health in the last 24 hours
(i.e. fever, chills, new cough, or diarrhea) _____ | | |
| 15. asthma _____ | | | 49. taking medication for weight management _____ | | |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) | | | 50. taking dietary supplements _____ | | |
| 17. kidney disease _____ | | | 51. often exhausted or fatigued _____ | | |
| 18. liver disease _____ | | | 52. experiencing frequent headaches _____ | | |
| 19. jaundice _____ | | | 53. a smoker, smoked previously or use smokeless tobacco _____ | | |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | | | 54. considered a touchy / sensitive person _____ | | |
| 21. hormone deficiency _____ | | | 55. often unhappy or depressed _____ | | |
| 22. high cholesterol or taking statin drugs _____ | | | 56. FEMALE - taking birth control pills _____ | | |
| 23. diabetes (HbA1c = _____) _____ | | | 57. FEMALE - pregnant _____ | | |
| 24. stomach or duodenal ulcer _____ | | | 58. MALE - prostate disorders _____ | | |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____ | | | | | |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | | | | | |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
 (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____