

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 _____
 2. an allergic reaction to
 - aspirin, ibuprofen, acetaminophen, codeine _____
 - penicillin _____
 - erythromycin _____
 - tetracycline _____
 - sulfa _____
 - local anesthetic _____
 - fluoride _____
 - metals (nickel, gold, silver, _____)
 - latex _____
 - other _____
 3. heart problems, or cardiac stent within the last six months _____
 4. history of infective endocarditis _____
 5. artificial heart valve, repaired heart defect (PFO) _____
 6. pacemaker or implantable defibrillator _____
 7. artificial prosthesis (heart valve or joints) _____
 8. rheumatic or scarlet fever _____
 9. high or low blood pressure _____
 10. a stroke (taking blood thinners) _____
 11. anemia or other blood disorder _____
 12. prolonged bleeding due to a slight cut (INR > 3.5) _____
 13. emphysema, shortness of breath, sarcoidosis _____
 14. tuberculosis, measles, chicken pox _____
 15. asthma _____
 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____
 17. kidney disease _____
 18. liver disease _____
 19. jaundice _____
 20. thyroid, parathyroid disease, or calcium deficiency _____
 21. hormone deficiency _____
 22. high cholesterol or taking statin drugs _____
 23. diabetes (HbA1c = _____) _____
 24. stomach or duodenal ulcer _____
 25. digestive disorders (i.e. celiac disease, gastric reflux) _____
 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____
 27. arthritis, rheumatoid arthritis, lupus _____
 28. glaucoma _____
 29. contact lenses _____
 30. head or neck injuries _____
 31. epilepsy, convulsions (seizures) _____
 32. neurologic disorders (ADD/ADHD, prion disease) _____
 33. viral infections and cold sores _____
 34. any lumps or swelling in the mouth _____
 35. hives, skin rash, hay fever _____
 36. STI/STD _____
 37. hepatitis (type _____) _____
 38. HIV / AIDS _____
 39. tumor, abnormal growth _____
 40. radiation therapy _____
 41. chemotherapy, immunosuppressive _____
 42. emotional problems _____
 43. psychiatric treatment _____
 44. antidepressant medication _____
 45. alcohol / street drug use _____

ARE YOU:

46. presently being treated for any other illness _____
47. aware of a change in your health in the last 24 hours
(i.e. fever, chills, new cough, or diarrhea) _____
48. taking medication for weight management (i.e. fen-phen) _____
49. taking dietary supplements _____
50. often exhausted or fatigued _____
51. experiencing frequent headaches _____
52. a smoker, smoked previously or use smokeless tobacco _____
53. considered a touchy person _____
54. often unhappy or depressed _____
55. FEMALE - taking birth control pills _____
56. FEMALE - pregnant _____
57. MALE - prostate disorders _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

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 _____