

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 | |
|--|------------|-----------|--|
1. hospitalization for illness or injury _____
 2. an allergic or bad reaction to any of the following:
 - aspirin, ibuprofen, acetaminophen, codeine
 - penicillin
 - erythromycin
 - tetracycline
 - sulfa
 - local anesthetic
 - fluoride
 - chlorhexidine (CHX)
 - metals (nickel, gold, silver, _____)
 - latex
 - nuts _____
 - fruit _____
 - 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. orthopedic implant (joint replacement) _____
 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. pneumonia, emphysema, shortness of breath, sarcoidosis ____
 14. chronic ear infections, 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 or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____
 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ____
 27. arthritis _____
 28. autoimmune disease _____
(i.e. rheumatoid arthritis, lupus, scleroderma)
 29. glaucoma _____
 30. contact lenses _____
 31. head or neck injuries _____
 32. epilepsy, convulsions (seizures) _____
 33. neurologic disorders (ADD/ADHD, prion disease) _____
 34. viral infections and cold sores _____
 35. any lumps or swelling in the mouth _____
 36. hives, skin rash, hay fever _____
 37. STI/STD/HPV _____
 38. hepatitis (type ____)
 39. HIV/AIDS _____
 40. tumor, abnormal growth _____
 41. radiation therapy _____
 42. chemotherapy, immunosuppressive medication _____
 43. emotional difficulties _____
 44. psychiatric treatment _____
 45. antidepressant medication _____
 46. alcohol/recreational drug use _____
- ARE YOU:**
47. presently being treated for any other illness _____
 48. aware of a change in your health in the last 24 hours
(i.e. fever, chills, new cough, or diarrhea) _____
 49. taking medication for weight management _____
 50. taking dietary supplements _____
 51. often exhausted or fatigued _____
 52. experiencing frequent headaches _____
 53. a smoker, smoked previously or use smokeless tobacco ____
 54. considered a touchy/sensitive person _____
 55. often unhappy or depressed _____
 56. taking birth control pills _____
 57. currently pregnant _____
 58. diagnosed with a prostate disorder _____

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 _____