

MEDICAL HISTORY

Fill out, print and bring to your appointment

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 or bad reaction to any of the following:
 - aspirin, ibuprofen, acetaminophen, codeine
 - penicillin
 - erythromycin
 - tetracycline
 - sulfa
 - local anesthetic
 - fluoride
 - 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. 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 _____