

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 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 _____

