

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 _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa | | | 32. neurologic problems (attention deficit disorder) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. STI / STD _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / street drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. emphysema, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. aware of a change in your health (i.e. fever, new cough) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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 _____

