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:

- ☐ hospitalization for illness or injury_____
- ☐ an allergic reaction to
  - ☐ aspirin, ibuprofen, acetaminophen, codeine
  - ☐ penicillin
  - ☐ erythromycin
  - ☐ tetracycline
  - ☐ sulfa
  - ☐ local anesthetic
  - ☐ fluoride
  - ☐ metals (nickel, gold, silver,_____)
  - ☐ latex
  - ☐ other _____
- ☐ heart problems, or cardiac stent within the last six months _____
- ☐ history of infective endocarditis _____
- ☐ artificial heart valve, repaired heart defect (PFO) _____
- ☐ pacemaker or implantable defibrillator _____
- ☐ artificial prosthesis (heart valve or joints) _____
- ☐ rheumatic or scarlet fever_____
- ☐ high or low blood pressure_____
- ☐ a stroke (taking blood thinners) _____
- ☐ anemia or other blood disorder_____
- ☐ prolonged bleeding due to a slight cut (INR > 3.5) _____
- ☐ emphysema, shortness of breath, sarcoidosis _____
- ☐ tuberculosis, measles, chicken pox, shingles_____
- ☐ asthma_____
- ☐ breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
- ☐ kidney disease _____
- ☐ liver disease _____
- ☐ jaundice _____
- ☐ thyroid, parathyroid disease, or calcium deficiency _____
- ☐ hormone deficiency_____
- ☐ high cholesterol or taking statin drugs _____
- ☐ diabetes (HbA1c=_____) _____
- ☐ stomach or duodenal ulcer _____
- ☐ digestive disorders (i.e. celiac disease, gastric reflux) _____
- ☐ osteoporosis/osteopenia (i.e. taking bisphosphonates like Fosamax, Boniva, Actonel, etc.) _____
- ☐ arthritis, rheumatoid arthritis, lupus _____
- ☐ glaucoma_____
- ☐ contact lenses _____
- ☐ head or neck injuries _____
- ☐ epilepsy, convulsions (seizures) _____
- ☐ neurologic disorders (ADD/ADHD, prion disease) _____
- ☐ alzheimer's disease _____
- ☐ renal dialysis _____
- ☐ viral infections and cold sores _____
- ☐ any lumps or swelling in the mouth_____
- ☐ hives, skin rash, hay fever_____
- ☐ STI / STD _____
- ☐ hepatitis (type____) _____
- ☐ HIV / AIDS _____
- ☐ tumor, abnormal growth_____
- ☐ radiation therapy_____
- ☐ chemotherapy, immunosuppressive_____
- ☐ emotional problems _____
- ☐ psychiatric treatment_____
- ☐ antidepressant medication _____
- ☐ alcohol / street drug use _____

ARE YOU:

- ☐ presently being treated for any other illness _____
- ☐ aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)_____
- ☐ taking medication for weight management (i.e. fen-phen)
- ☐ taking dietary supplements_____
- ☐ often exhausted or fatigued _____
- ☐ experiencing frequent headaches_____
- ☐ a smoker, smoked previously or use smokeless tobacco _
- ☐ considered a touchy person _____
- ☐ often unhappy or depressed_____
- ☐ FEMALE - taking birth control pills _____
- ☐ FEMALE – pregnant/trying to get pregnant _____
- ☐ FEMALE – nursing _____
- ☐ 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 one 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 _____