

# 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

- |  |            |           |  |            |           |
|--|------------|-----------|--|------------|-----------|
| <b>DO YOU HAVE or HAVE YOU EVER HAD:</b> | <b>YES</b> | <b>NO</b> |  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|--|------------|-----------|
1. hospitalization for illness or injury \_\_\_\_\_
  2. an allergic reaction to
    - aspirin, ibuprofen, acetaminophen, codeine
    - penicillin
    - erythromycin
    - tetracycline
    - sulfa
    - local anesthetic
    - fluoride
    - metals (nickel, gold, silver, \_\_\_\_\_)
    - latex
    - 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. 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 disorders (i.e. celiac disease, gastric reflux) \_\_\_\_\_
  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. FEMALE - taking birth control pills \_\_\_\_\_
  57. FEMALE - pregnant \_\_\_\_\_
  58. 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 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 \_\_\_\_\_