MEDICAL HISTORY

Patient Name

Nickname

Age

Name of Physician/and their specialty

Most recent physical examination

What is your estimate of your general health?

- Excellent
- Good
- Fair
- Poor

DO YOU HAVE OR HAVE YOU EVER HAD:

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. artificial prosthesis (heart valve or joints)
8. rheumatic or scarlet fever
9. high or low blood pressure
10. a stroke (taking blood thinners)
11. anemia or other blood disorder(s)
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, rheumatoid arthritis, lupus
28. glaucoma
29. contact lenses
30. head or neck injuries
31. epilepsy, convulsions (seizures)
32. neurologic disorders (ADD/ADHD, prion disease)
33. viral infections and cold sores
34. any lumps or swelling in the mouth
35. hives, skin rash, hay fever
36. STI/STD
37. hepatitis (type_____)
38. HIV/AIDS
39. tumor, abnormal growth
40. radiation therapy
41. chemotherapy, immunosuppressive
42. emotional problems
43. psychiatric treatment
44. antidepressant medication
45. alcohol/street drug use

ARE YOU:

46. presently being treated for any other illness
47. aware of a change I your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)
48. taking medication for weight management (i.e. fen-phen)
49. taking dietary supplements
50. often exhausted or fatigued
51. experiencing frequent headaches
52. a smoker, smoked previously or used smokeless tobacco
53. consider a touchy person
54. often unhappy or depressed
55. FEMALE – taking birth control pills
56. FEMALE – pregnant
57. 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

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