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

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) __

YES NO

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 ______________

ASA ______ (1-6)

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