

# 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"/>	27.	arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	28.	autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			30.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			31.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			32.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			33.	neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			34.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			35.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			36.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex			37.	STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			38.	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"/>	39.	HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>			
12.	prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56.	taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	58.	prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>				
25.	digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>				
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 \_\_\_\_\_