MEDICAL HISTORY

Name _____ Prefer to be called _____ Age _____

Phone (1) _____ Phone (2) _____ Email _____

Name of Physician / and their specialty _____

Most recent physical examination _____ Purpose _____

How would you rate your overall 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. 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 _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness or 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 medication _____	☐	☐
23. diabetes (HbA1c= type 1 or 2) _____	☐	☐
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, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses / glasses _____	☐	☐
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 _____	☐	☐
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 / excessive or daily street drug use _____		
List drugs (if applicable) _____		
_____		
ARE YOU:		
46. presently being treated for other illness _____	☐	☐
47. aware of a change in 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 use chewing tobacco	☐	☐
53. history of depression _____	☐	☐
54. FEMALE - taking birth control pills _____	☐	☐
55. FEMALE - pregnant _____	☐	☐
56. MALE - prostate disorders _____	☐	☐
	☐	☐

Describe any current medical treatment, impending surgery, genetic / developmental delay, or other treatment that may possibly affect your dental treatment (i.s. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Please 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 _____