

# 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:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____                       | YES                      | NO                       |
| 2. an allergic reaction to _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine  |                          |                          |
| <input type="checkbox"/> penicillin                                  |                          |                          |
| <input type="checkbox"/> erythromycin                                |                          |                          |
| <input type="checkbox"/> tetracycline                                |                          |                          |
| <input type="checkbox"/> sulfa                                       |                          |                          |
| <input type="checkbox"/> local anesthetic                            |                          |                          |
| <input type="checkbox"/> fluoride                                    |                          |                          |
| <input type="checkbox"/> metals (nickel, gold, silver, _____)        |                          |                          |
| <input type="checkbox"/> latex                                       |                          |                          |
| <input type="checkbox"/> other _____                                 |                          |                          |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____               | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. emphysema, sarcoidosis _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____          | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____        | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. gastric reflux) _____                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | YES                      | NO                       |
| 27. arthritis _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. glaucoma _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. contact lenses _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. head or neck injuries _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. epilepsy, convulsions (seizures) _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. neurologic problems (attention deficit disorder) _____      | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. viral infections and cold sores _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. any lumps or swelling in the mouth _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. hives, skin rash, hay fever _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. STI / STD _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. hepatitis (type _____) _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. HIV / AIDS _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. tumor, abnormal growth _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. radiation therapy _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. chemotherapy _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. emotional problems _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. psychiatric treatment _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. antidepressant medication _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. alcohol / street drug use _____                             | <input type="checkbox"/> | <input type="checkbox"/> |

**ARE YOU:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 46. presently being treated for any other illness _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. aware of a change in your health (i.e. fever, new cough) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. taking medication for weight management (i.e. fen-phen) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. taking dietary supplements _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. often exhausted or fatigued _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. experiencing frequent headaches _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. a smoker, smoked previously or use smokeless tobacco _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. considered a touchy person _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. often unhappy or depressed _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. FEMALE - taking birth control pills _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. FEMALE - pregnant _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. MALE - prostate disorders _____                                | <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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 \_\_\_\_\_