# 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 or bad reaction to any of the following: | ☐ | ☐ |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulfa | | |
| ☐ local anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ nuts _____ | | |
| ☐ fruit _____ | | |
| ☐ 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. pneumonia, 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 or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___ | ☐ | ☐ |
| 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. taking birth control pills _____ | ☐ | ☐ |
| 57. currently pregnant _____ | ☐ | ☐ |
| 58. diagnosed with a prostate disorder _____ | ☐ | ☐ |

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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