

# 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 \_\_\_\_\_
2. an allergic or bad reaction to any of the following:
  - aspirin, ibuprofen, acetaminophen, codeine
  - penicillin
  - erythromycin
  - tetracycline
  - sulfa
  - local anesthetic
  - fluoride
  - chlorhexidine (CHX)
  - 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. chronic ear infections, tuberculosis, measles, chicken pox \_\_\_\_\_
15. asthma \_\_\_\_\_
16. breathing or sleep problems (e.g., 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) \_\_\_\_\_

26. osteoporosis/osteopenia (e.g., taking bisphosphonates) \_\_\_\_\_
27. arthritis \_\_\_\_\_
28. autoimmune disease (e.g., 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 (e.g., 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 \_\_\_\_\_