

MEDICAL HISTORY

Name of your 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

- | | |
|---|---|
| <p>1. hospitalization for illness or injury _____ ☐ ☐</p> <p>2. an allergic reaction to _____</p> <p style="margin-left: 20px;">☐ aspirin</p> <p style="margin-left: 20px;">☐ penicillin</p> <p style="margin-left: 20px;">☐ erythromycin</p> <p style="margin-left: 20px;">☐ tetracycline</p> <p style="margin-left: 20px;">☐ sulfa</p> <p style="margin-left: 20px;">☐ local anesthetic</p> <p style="margin-left: 20px;">☐ fluoride</p> <p style="margin-left: 20px;">☐ metals (nickel, gold, silver, _____)</p> <p style="margin-left: 20px;">☐ latex</p> <p style="margin-left: 20px;">☐ other _____</p> <p>3. heart problems, or cardiac stent within the last six months _____ ☐ ☐</p> <p>4. history of infective endocarditis _____ ☐ ☐</p> <p>5. artificial heart valve, repaired heart defect (PFO) _____ ☐ ☐</p> <p>6. pacemaker or implantable defibrillator _____ ☐ ☐</p> <p>7. orthopedic implant (joint replacement) _____ ☐ ☐</p> <p>8. rheumatic or scarlet fever _____ ☐ ☐</p> <p>9. high or low blood pressure _____ ☐ ☐</p> <p>10. a stroke (taking blood thinners) _____ ☐ ☐</p> <p>11. anemia or other blood disorder _____ ☐ ☐</p> <p>12. prolonged bleeding due to a slight cut (INR>3.5) _____ ☐ ☐</p> <p>13. emphysema, shortness of breath, sarcoidosis _____ ☐ ☐</p> <p>14. tuberculosis, measles, chicken pox _____ ☐ ☐</p> <p>15. asthma _____ ☐ ☐</p> <p>16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____ ☐ ☐</p> <p>17. kidney disease _____ ☐ ☐</p> <p>18. liver disease _____ ☐ ☐</p> <p>19. jaundice _____ ☐ ☐</p> <p>20. thyroid, parathyroid disease, or calcium deficiency _____ ☐ ☐</p> <p>21. hormone deficiency _____ ☐ ☐</p> <p>22. high cholesterol or taking statin drugs _____ ☐ ☐</p> <p>23. diabetes (HbA1c= _____) _____ ☐ ☐</p> <p>24. stomach or duodenal ulcer _____ ☐ ☐</p> <p>25. digestive disorders (i.e. celiac disease, gastric reflux) _____ ☐ ☐</p> | <p>26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ ☐ ☐</p> <p>27. arthritis _____ ☐ ☐</p> <p>28. autoimmune disease _____</p> <p style="margin-left: 20px;">(i.e. rheumatoid arthritis, lupus, scleroderma) _____ ☐ ☐</p> <p>29. glaucoma _____ ☐ ☐</p> <p>30. head or neck injuries _____ ☐ ☐</p> <p>31. epilepsy, convulsions (seizures) _____ ☐ ☐</p> <p>32. neurologic disorder (ADD/ADHD, prion disease) _____ ☐ ☐</p> <p>33. viral infections and cold sores _____ ☐ ☐</p> <p>34. any lumps or swelling in the mouth _____ ☐ ☐</p> <p>35. hives, skin rash, hay fever _____ ☐ ☐</p> <p>36. STI/STD/HPV _____ ☐ ☐</p> <p>37. hepatitis (type _____) _____ ☐ ☐</p> <p>38. HIV/AIDS _____ ☐ ☐</p> <p>39. tumor, abnormal growth _____ ☐ ☐</p> <p>40. radiation therapy _____ ☐ ☐</p> <p>41. chemotherapy, immunosuppressive medication _____ ☐ ☐</p> <p>42. emotional difficulties _____ ☐ ☐</p> <p>43. psychiatric treatment _____ ☐ ☐</p> <p>44. antidepressant medication _____ ☐ ☐</p> <p>45. alcohol use _____ ☐ ☐</p> <p>46. recreational drug use _____ ☐ ☐</p> <p style="text-align: center;">ARE YOU:</p> <p>47. presently being treated for any other illness _____ ☐ ☐</p> <p>48. aware of a change in your health in the last 24 hours _____</p> <p style="margin-left: 20px;">(i.e. fever, chills, new cough, or diarrhea) _____ ☐ ☐</p> <p>49. taking medication for weight management _____ ☐ ☐</p> <p>50. taking dietary supplements _____ ☐ ☐</p> <p>51. often exhausted or fatigued _____ ☐ ☐</p> <p>52. experiencing frequent headaches _____ ☐ ☐</p> <p>53. a smoker, smoked previously or use smokeless tobacco _____ ☐ ☐</p> <p>54. often unhappy or depressed _____ ☐ ☐</p> <p>55. FEMALE – taking birth control pills _____ ☐ ☐</p> <p>56. FEMALE – pregnant or breast-feeding _____ ☐ ☐</p> <p>57. MALE – prostate disorders _____ ☐ ☐</p> |
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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.

Date

Print Name

Signature :
Patient () Parent () Guardian ()