MEDICAL HISTORY

Patient First Name
-

Patient Last Name
-

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
-

2. an allergic or bad reaction to any of the following:

aspirin, ibuprofen, acetaminophen, codeine
-

penicillin
-

erythromycin
-

tetracycline
-

sulfa
-

local anesthetic
-

fluoride
-

metals
-

Please elaborate the metals (metals (nickel, gold, silver, _____)
-

latex
-

nuts
-

fruit
-

other
-

If Other, Please Elaborate
-

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)
-

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.

Please mention ALL the DRUGS taken & PURPOSE for EACH
-

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature
-

Date
-