

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 _____
 - ☐ milk _____
 - ☐ red dye _____
 - ☐ 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 or soft tissue implant (e.g joint replacement, breast implant) _____
8. heart murmur, 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 (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g. "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____
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) _____

- | | | | | | |
|--------------------------|--------------------------|-----|--|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 16. | osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. | arthritis or gout | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 28. | autoimmune disease
(e.g. rheumatoid arthritis, lupus, scleroderma) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 29. | glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 30. | contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 31. | head or neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 32. | epilepsy, convulsions (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 33. | neurologic disorders (ADD/ADHD, prion disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 34. | viral infections and cold sores | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 35. | any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 36. | hives, skin rash, hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 37. | STI/STD/HPV | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 38. | hepatitis (type ____) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 39. | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 40. | tumor, abnormal growth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 41. | radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 42. | chemotherapy, immunosuppressive medication | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 43. | emotional difficulties | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 44. | psychiatric treatment or antidepressant medication | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 45. | concentration problems or ADD/ADHD diagnosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 46. | alcohol/recreational drug use | <input type="checkbox"/> | <input type="checkbox"/> |

ARE YOU:

- | | | | | |
|-----|---|-------|--------------------------|--------------------------|
| 47. | presently being treated for any other illness | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. | aware of a change in your health in the last 24 hours | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | (e.g., fever, chills, new cough, or diarrhea) | _____ | | |
| 49. | taking medication for weight management | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. | taking dietary supplements | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. | often exhausted or fatigued | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. | experiencing frequent headaches or chronic pain | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. | a smoker, smoked previously or use smokeless tobacco | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. | considered a touchy/sensitive person | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. | often unhappy or depressed | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. | taking birth control pills | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. | currently pregnant | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. | diagnosed with a prostate disorder | _____ | <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

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 _____