Medical History

Patient Name:_____ Preferred Name:_____ Age:_____
Physician Name/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:	Y	N
1 Hospitalization for illness or injury_____	☐	☐
2 An allergic reaction to _____	☐	☐
☐ Aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other:_____		
3 Heart problems, cardiac stent within the last 6 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 to minor cut (INR>3.5)_____	☐	☐
13 Emphysema, shortness of breath, sarcoidosis_____	☐	☐
14 Tuberculosis, Measles, Chicken Pox_____	☐	☐
15 Asthma_____	☐	☐
16 Breathing problems_____	☐	☐
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 Disorders (i.e. celiac disease, gastric reflux)_____	☐	☐
26 osteoporosis/osteopenia (i.e. taking bisphosphonates)__	☐	☐

	Y	N
27 Arthritis_____	☐	☐
28 Autoimmune disease_____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29 Glaucoma_____	☐	☐
30 Wear contact lenses_____	☐	☐
31 Head or neck injuries_____	☐	☐
32 Epilepsy or 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 Hepatits (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 Prostate disorders_____	☐	☐

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)