# MEDICAL HISTORY

Patient Name_____ Nickname_____ Age_____

Name of Physician / and their specialty_____

Most recent physical examination_____

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 | Yes ☐ | No ☐ | | |
| 2. | An allergic reaction to: | | | | |
| | a. Aspirin, ibuprofen, acetaminophen , codeine | Yes ☐ | No ☐ | | |
| | b. Penicillin | Yes ☐ | No ☐ | | |
| | c. Erythromycin | Yes ☐ | No ☐ | | |
| | d. Tetracycline | Yes ☐ | No ☐ | | |
| | e. Sulpha | Yes ☐ | No ☐ | | |
| | f. Local anesthetic | Yes ☐ | No ☐ | | |
| | g. Fluoride | Yes ☐ | No ☐ | | |
| | h. Metals, (nickel, gold, silver, _____) | Yes ☐ | No ☐ | | |
| | i. Latex | Yes ☐ | No ☐ | | |
| | j. Other _____ | Yes ☐ | No ☐ | | |
| 3. | Heart problems, or cardiac stent | Yes ☐ | No ☐ | | |
| 4. | History of infective endocarditis | Yes ☐ | No ☐ | | |
| 5. | Artificial heart valve, repaired heart defect (PFO) | Yes ☐ | No ☐ | | |
| 6. | Pacemaker or implantable defibrillator | Yes ☐ | No ☐ | | |
| 7. | Artificial prosthesis (heart valve or joints) | Yes ☐ | No ☐ | | |
| 8. | Rheumatic or scarlet fever | Yes ☐ | No ☐ | | |
| 9. | High or low blood pressure | Yes ☐ | No ☐ | | |
| 10. | A stroke (taking blood thinners) | Yes ☐ | No ☐ | | |
| 11. | Anemia or other blood disorder | Yes ☐ | No ☐ | | |
| 12. | Prolonged bleeding due to a slight cut (INR>3.5) | Yes ☐ | No ☐ | | |
| 13. | Emphysema, sarcoidosis | Yes ☐ | No ☐ | | |
| 14. | Tuberculosis | Yes ☐ | No ☐ | | |
| 15. | Have you had recent exposure to communicable infectious diseases (measles, chicken pox, TB, Prion disease, or travel to endemic area) | Yes ☐ | No ☐ | | |
| 16. | In the last 24 hours have you had new cough, shortness of breath, fever, chills, diarrhea or other flu like symptoms | Yes ☐ | No ☐ | | |
| 17. | Asthma | Yes ☐ | No ☐ | | |
| 18. | Breathing or sleep problems (i.e. snoring, sinus) | Yes ☐ | No ☐ | | |
| 19. | Kidney disease | Yes ☐ | No ☐ | | |
| 20. | Liver disease | Yes ☐ | No ☐ | | |
| 21. | Jaundice | Yes ☐ | No ☐ | | |
| 22. | Thyroid, parathyroid disease, or calcium deficiency | Yes ☐ | No ☐ | | |
| 23. | Hormone deficiency | Yes ☐ | No ☐ | | |
| 24. | High cholesterol or taking statin drugs | Yes ☐ | No ☐ | | |
| 25. | Diabetes (HbA1c=_____) | Yes ☐ | No ☐ | | |
| 26. | Stomach or duodenal ulcer | Yes ☐ | No ☐ | | |
| 27. | Digestive disorders (i.e. gastric reflux) | Yes ☐ | No ☐ | | |
| 28. | Osteoporosis/osteopenia (i.e. taking bisphosphonates) | Yes ☐ | No ☐ | | |
| 29. | Arthritis | Yes ☐ | No ☐ | | |
| 30. | Glaucoma | Yes ☐ | No ☐ | | |
| 31. | Contact lenses | Yes ☐ | No ☐ | | |
| 32. | Head or neck injuries | Yes ☐ | No ☐ | | |
| 33. | Epilepsy, convulsions (seizures) | Yes ☐ | No ☐ | | |
| 34. | Neurologic problems (attention deficit disorder) | Yes ☐ | No ☐ | | |
| 35. | Viral infections and cold sores | Yes ☐ | No ☐ | | |
| 36. | Any lumps or swelling in the mouth | Yes ☐ | No ☐ | | |
| 37. | Hives, skin rash, hay fever | Yes ☐ | No ☐ | | |
| 38. | Venereal disease | Yes ☐ | No ☐ | | |
| 39. | Hepatitis (type_____) | Yes ☐ | No ☐ | | |
| 40. | HIV / AIDS | Yes ☐ | No ☐ | | |
| 41. | Tumor, abnormal growth | Yes ☐ | No ☐ | | |
| 42. | Radiation therapy | Yes ☐ | No ☐ | | |
| 43. | Chemotherapy | Yes ☐ | No ☐ | | |
| 44. | Emotional problems | Yes ☐ | No ☐ | | |
| 45. | Psychiatric treatment | Yes ☐ | No ☐ | | |
| 46. | Antidepressant medication | Yes ☐ | No ☐ | | |
| 47. | Alcohol / drug dependency | Yes ☐ | No ☐ | | |

**ARE YOU:**

| | | | | | |
|---|---|---|---|---|---|
| 48. | Presently being treated for any other illness | Yes ☐ | No ☐ | | |
| 49. | Aware of a change in your general health | Yes ☐ | No ☐ | | |
| 50. | Taking medication for weight management (i.e. fen-phen) | Yes ☐ | No ☐ | | |
| 51. | Taking dietary supplements | Yes ☐ | No ☐ | | |
| 52. | Often exhausted or fatigued | Yes ☐ | No ☐ | | |
| 53. | Subject to frequent headaches | Yes ☐ | No ☐ | | |
| 54. | A smoker or smoked previously | Yes ☐ | No ☐ | | |
| 55. | Considered a touchy (sensitive) person | Yes ☐ | No ☐ | | |
| 56. | Often unhappy or depressed | Yes ☐ | No ☐ | | |
| 57. | FEMALE – taking birth control pills | Yes ☐ | No ☐ | | |
| 58. | FEMALE – pregnant | Yes ☐ | No ☐ | | |
| 59. | MALE – prostate disorders | Yes ☐ | No ☐ | | |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years. Ask for an additional sheet if you are taking more than 6 medications.

| 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_____