

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

Ask for an additional sheet if you are taking more than 6 medications

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 _____

