

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 _____	☐	☐	27. arthritis _____	☐	☐
2. an allergic reaction to _____			28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine			29. glaucoma _____	☐	☐
☐ penicillin			30. contact lenses _____	☐	☐
☐ erythromycin			31. head or neck injuries _____	☐	☐
☐ tetracycline			32. epilepsy, convulsions (seizures) _____	☐	☐
☐ sulfa			33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
☐ local anesthetic			34. viral infections and cold sores _____	☐	☐
☐ fluoride			35. any lumps or swelling in the mouth _____	☐	☐
☐ metals (nickel, gold, silver, _____)			36. hives, skin rash, hay fever _____	☐	☐
☐ latex			37. STI / STD / HPV _____	☐	☐
☐ other _____			38. hepatitis (type _____)	☐	☐
3. heart problems, or cardiac stent within the last six months _____	☐	☐	39. HIV / AIDS _____	☐	☐
4. history of infective endocarditis _____	☐	☐	40. tumor, abnormal growth _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐	41. radiation therapy _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐	42. chemotherapy, immunosuppressive medication _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐	43. emotional difficulties _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐	44. psychiatric treatment _____	☐	☐
9. high or low blood pressure _____	☐	☐	45. antidepressant medication _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐	46. alcohol / recreational drug use _____	☐	☐
11. anemia or other blood disorder _____	☐	☐	ARE YOU:		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐	47. presently being treated for any other illness _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐	49. taking medication for weight management _____	☐	☐
15. asthma _____	☐	☐	50. taking dietary supplements _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	☐	☐	51. often exhausted or fatigued _____	☐	☐
17. kidney disease _____	☐	☐	52. experiencing frequent headaches _____	☐	☐
18. liver disease _____	☐	☐	53. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
19. jaundice _____	☐	☐	54. considered a touchy / sensitive person _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐	55. often unhappy or depressed _____	☐	☐
21. hormone deficiency _____	☐	☐	56. FEMALE - taking birth control pills _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐	57. FEMALE - pregnant _____	☐	☐
23. diabetes (HbA1c = _____)	☐	☐	58. MALE - prostate disorders _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐			
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐			
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐			

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 _____

