Medical History

Patient Name ____________________ Name of Physician ____________________

Specialty of Physician ____________________ Phone number of Physician ____________________

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**

1. alcohol/recreational drug use ☐ ☐
2. an allergic reaction to ☐ ☐
   - ◯ Aspirin, ibuprofen, acetaminophen, codeine
   - ◯ Erythromycin
   - ◯ Fluoride
   - ◯ Latex
   - ◯ Local anesthetic
   - ◯ Metals (nickel, gold, silver, ____________)
   - ◯ Penicillin
   - ◯ Sulfa
   - ◯ Tetracycline
   - ◯ Other ____________________
3. anemia or other blood disorder ☐ ☐
4. antidepressant medication ☐ ☐
5. arthritis ☐ ☐
6. artificial heart valve, repaired heart defect (PFO) ☐ ☐
7. asthma ☐ ☐
8. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ☐ ☐
9. breathing or sleep problems (e.g., sleep apnea, snoring, sinus) ☐ ☐
10. chemotherapy, immunosuppressive medication ☐ ☐
11. contact lenses ☐ ☐
12. diabetes (HbA1c=______) ☐ ☐
13. digestive disorders (e.g., celiac disease, gastric reflux) ☐ ☐
14. emotional difficulties ☐ ☐
15. emphysema, shortness of breath, sarcoidosis ☐ ☐
16. epilepsy, convulsions (seizures) ☐ ☐
17. glaucoma ☐ ☐
18. head or neck injuries ☐ ☐
19. heart problems or cardiac stent within the last six months ☐ ☐
20. hepatitis (type ______) ☐ ☐
21. high cholesterol or taking statin drugs ☐ ☐
22. high or low blood pressure ☐ ☐
23. HIV/AIDS ☐ ☐
24. hives, skin rash, hay fever ☐ ☐
25. hormone deficiency ☐ ☐

YES **NO**

26. hospitalization for illness or injury ☐ ☐
27. history of infective endocarditis ☐ ☐
28. an inhaler, nitroglycerin, an epi pen, or glucometer? If yes, bring to all appointments ☐ ☐
29. jaundice ☐ ☐
30. kidney disease ☐ ☐
31. liver disease ☐ ☐
32. any lumps or swelling in the mouth ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) ☐ ☐
34. orthopedic implant (joint replacement) ☐ ☐
35. osteoporosis/osteopenia (e.g., taking bisphosphonates) ☐ ☐
36. pacemaker or implantable defibrillator ☐ ☐
37. prolonged bleeding due to a slight cut (INR > 3.5) ☐ ☐
38. psychiatric treatment ☐ ☐
39. radiation therapy ☐ ☐
40. rheumatic or scarlet fever ☐ ☐
41. STI/STD/HPV ☐ ☐
42. stomach or duodenal ulcer ☐ ☐
43. a stroke (taking blood thinners) ☐ ☐
44. thyroid, parathyroid disease, or calcium deficiency ☐ ☐
45. tuberculosis, measles, chicken pox ☐ ☐
46. tumor, abnormal growth ☐ ☐
47. viral infections and cold sores ☐ ☐

Are you:

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

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (e.g., 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)