

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

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) 