

MEDICAL HISTORY

Patient Name _____ Age _____

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

| 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 _____