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

1. hospitalization for illness or injury ____________ ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ chlorhexidine (CHX)
   - ☐ metals (nickel, gold, silver, ____________)
   - ☐ latex ____________
   - ☐ nuts ____________
   - ☐ fruit ____________
   - ☐ milk ____________
   - ☐ red dye ____________
   - ☐ other ____________
3. heart problems, or cardiac stent within the last six months ____ ☐ ☐
4. history of infective endocarditis ____ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ____ ☐ ☐
6. pacemaker or implantable defibrillator ____ ☐ ☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ____ ☐ ☐
8. heart murmur, rheumatic or scarlet fever ____ ☐ ☐
9. high or low blood pressure ____ ☐ ☐
10. a stroke (taking blood thinners) ____ ☐ ☐
11. anemia or other blood disorder ____ ☐ ☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) ____ ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ____ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox ____ ☐ ☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) ____ ☐ ☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) ____ ☐ ☐
17. kidney disease ____ ☐ ☐
18. liver disease or jaundice ____ ☐ ☐
19. vertigo (e.g. "the room is spinning") ____ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ____ ☐ ☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____ ☐ ☐
22. high cholesterol or taking statin drugs ____ ☐ ☐
23. diabetes (HbA1c = ________) ____ ☐ ☐
24. stomach or duodenal ulcer ____ ☐ ☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) ____ ☐ ☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) ____ ☐ ☐
27. arthritis or gout ____ ☐ ☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) ____ ☐ ☐
29. glaucoma ____ ☐ ☐
30. contact lenses ____ ☐ ☐
31. head or neck injuries ____ ☐ ☐
32. epilepsy, convulsions (seizures) ____ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) ____ ☐ ☐
34. viral infections and cold sores ____ ☐ ☐
35. any lumps or swelling in the mouth ____ ☐ ☐
36. hives, skin rash, hay fever ____ ☐ ☐
37. STI/STD/HPV ____ ☐ ☐
38. hepatitis (type ____) ____ ☐ ☐
39. HIV/AIDS ____ ☐ ☐
40. tumor, abnormal growth ____ ☐ ☐
41. radiation therapy ____ ☐ ☐
42. chemotherapy, immunosuppressive medication ____ ☐ ☐
43. emotional difficulties ____ ☐ ☐
44. psychiatric treatment or antidepressant medication ____ ☐ ☐
45. concentration problems or ADD/ADHD diagnosis ____ ☐ ☐
46. alcohol/recreational drug use ____ ☐ ☐

ARE YOU:

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

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)** ☐ ☐ ☐

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