Medical History

Patient Name: _____ Nickname_____Age_____
Name of Physician/and their specialty_____
Most recent physical examination_____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair

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:		
o Aspirin, ibuprofen acetaminophen, codeine		
o Penicillin		
o Erythromycin		
o Tetracycline		
o Sulfa		
o Local anesthetic		
o Fluoride		
o Chlorhexidine (CHX)		
o Metals (nickel, gold, silver, _____)		
o Latex		
o Nuts_____		
o Fruit_____		
o Milk_____		
o Red dye_____		
o 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. Sleeping 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, chill, 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. Taking birth control pills_____	☐	☐
55. Currently pregnant_____	☐	☐
56. 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_____
_____
_____

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient's Signature _____

Doctor's Signature_____