Medical History

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Name of physician/specialist and their speciality _____
Most recent doctor's visit and purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:

1. Hospitalization for illness or injury ☐
2. An allergic reaction to: ☐
   - ☐ Aspirin, ibuprofen, acetaminophen, codeine
   - ☐ Penicillin
   - ☐ Erythromcin
   - ☐ Tracycline
   - ☐ Sulpha
   - ☐ Local anesthetic
   - ☐ Fluoride
   - ☐ metals (nickel, gold, silver, ...)
   - ☐ Latex
   - Other
3. Heart problems, or cardiac stent within the last 6 months ☐
4. History of infective endocarditis ☐
5. Artificial heart valve, repaired heart defect (PFO) ☐
6. Pacemaker or implantable defibrillator ☐
7. Artifical prosthesis (heart valve or joints) ☐
8. 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 (INR > 3.5) ☐
13. Emphysema, srcoidosis ☐
14. Tuberculosis ☐
15. Asthma ☐
16. Breathing or sleep problems (i.e. snoring, sinus) ☐
17. Kidney disease ☐
18. Liver disease ☐
19. Jaundice ☐
20. Thyroid, parathiroid disease or calcium deficiency ☐
21. Hormone deficiency ☐
22. High cholesterol or taking statin drugs ☐
23. Diabetes (HbA1c=_____) ☐
24. Stomach or duodenal ulcer ☐
25. Digestive disorders (and/or gastric reflux) ☐
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates) ☐
27. Arthritis ☐
28. Glaucoma ☐
29. Contact lenses ☐
30. Head or neck injuries ☐
31. Epilepsy, convulsions (seizures) ☐
32. Neurolgic problems (attention deficit disorder) ☐
33. Viral infections and cold sores ☐
34. Any lumps or swelling in the mouth ☐
35. Mouth ulcers, fever blisters ☐
36. Hives, skin rash, hay fever ☐
37. Venereal disease ☐
38. Hepatitis (type _____) ☐
39. HIV / AIDS ☐
40. Tumor, abnormal growth ☐
41. Radiation therapy ☐
42. Chemotherapy ☐
43. Emotional problems ☐
44. Psychiatric treatment ☐
45. Antidepressant medication ☐
46. Alcohol/drug dependency ☐

Are you?

47. Presently being treated for any other illness ☐
48. Aware of a change in your health in the last 24 hours (Fever, chills, new cough or diarrhea) ☐
49. Taking medication for weigh management (i.e. fen-phen) ☐
50. Taking dietary supplements ☐
51. Often exhausted or fatigued ☐
52. Subject to frequent headaches ☐
53. A smoker or smoked previously ☐
54. Considered a touchy person ☐
55. Often unhappy or depressed ☐
56. FEMALE - taking birth control pills ☐
57. FEMALE - pregnant ☐
58. MALE - prostate disorders ☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years. (Drug and purpose)

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____