MEDICAL HISTORY

Patient Name____ Nickname_____________________________ Age____________

Name of Physician and their specialty____

Date of 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 reaction to:
   - ☐ aspirin, ibuprofen, acetaminophen
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ codeine
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (gold, stainless steel)
   - ☐ latex
   - ☐ other_____________________________________ ☐ ☐
3. heart problems__________________________________ ☐ ☐
4. high blood pressure_____________________________ ☐ ☐
5. low blood pressure______________________________ ☐ ☐
6. a stroke_______________________________________ ☐ ☐
7. artificial prosthesis (i.e. heart valves or joints)_______ ☐ ☐
8. prolonged bleeding due to a slight cut_____________ ☐ ☐
9. emphysema____________________________________ ☐ ☐
10. tuberculosis__________________________________ ☐ ☐
11. asthma______________________________________ ☐ ☐
12. breathing or sleeping problems (i.e. snoring, sinus)_ ☐ ☐
13. kidney disease________________________________ ☐ ☐
14. liver disease__________________________________ ☐ ☐
15. thyroid or parathyroid disease___________________ ☐ ☐
16. high cholesterol_______________________________ ☐ ☐
17. diabetes_____________________________________ ☐ ☐
18. stomach or duodenal ulcer_____________________ ☐ ☐

YES NO

19. digestive disorders (i.e. gastric reflux)_______________ ☐ ☐
20. osteoporosis/osteopenia (taking bisphosphonates)____ ☐ ☐
21. arthritis____ ☐ ☐
22. head or neck injuries____________________________ ☐ ☐
23. epilepsy, convulsions (seizures)____________________ ☐ ☐
24. neurologic problems_____________________________ ☐ ☐
25. viral infections and cold sores______________________ ☐ ☐
26. any lumps or swelling in the mouth_________________ ☐ ☐
27. hives, skin rash, hay fever________________________ ☐ ☐
28. venereal disease_________________________________ ☐ ☐
29. hepatitis (type____) ______________________________ ☐ ☐
30. HIV/AIDS_______________________________________ ☐ ☐
31. tumor, abnormal growth__________________________ ☐ ☐
32. radiation therapy________________________________ ☐ ☐
33. chemotherapy___________________________________ ☐ ☐
34. psychiatric treatment_____________________________ ☐ ☐
35. antidepressant medication_________________________ ☐ ☐
36. alcohol/drug dependency__________________________ ☐ ☐

ARE YOU:

37. presently being treatment for any other illness_______ ☐ ☐
38. aware of a change in your general health____________ ☐ ☐
39. taking dietary supplements________________________ ☐ ☐
40. often exhausted or fatigued_______________________ ☐ ☐
41. subject to frequent headaches_____________________ ☐ ☐
42. a smoker or smoked previously____________________ ☐ ☐
43. FEMALE – taking birth control pills_________________ ☐ ☐
44. FEMALE – pregnant and/or nursing_________________ ☐ ☐

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 (ask for additional sheet if necessary):

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**______________________