

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

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) _____
 - iodine _____
 - 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. polycystic 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 (e.g. Alzheimer's disease, dementia, 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 _____
- 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, vitamins, and/or probiotics _____
- 51. often exhausted or fatigued _____
- 52. experiencing frequent headaches or chronic pain _____
- 53. a smoker, smoked previously or other (e.g. 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, vitamins, and/or probiotics 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 _____