

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)
 - ☐ 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 (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

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 _____