



## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of general health?  EXCELLENT  GOOD  FAIR  POOR

DO YOU HAVE OR HAVE YOU EVER HAD:		YES	NO		YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>		21. hormone deficiency or imbalance (e.g. PCOS)	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following:	<input type="checkbox"/>	<input type="checkbox"/>		22. high cholesterol or taking statin drugs	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine				23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin				24. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin				25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline				26. osteoporosis/osteopenia (e.g. taking biphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa				27. arthritis or gout	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic				28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride				29. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iodine				30. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> milk				31. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> red dye				32. epilepsy/convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> chlorhexidine (CHX)				33. neurologic disorders (Alzheimer's disease, dementia, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)				34. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex _____				35. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> nuts _____				36. hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fruit _____				37. STI/STD/HPV	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____				38. hepatitis (Type ____)	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>		39. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
4. history of ineffective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>		40. tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO)	<input type="checkbox"/>	<input type="checkbox"/>		41. radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator	<input type="checkbox"/>	<input type="checkbox"/>		42. chemotherapy, immunosuppressive medication	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic or soft tissue implant (i.e. joint replacement, breast implant)	<input type="checkbox"/>	<input type="checkbox"/>		43. emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
8. heart murmur, rheumatic or scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>		44. psychiatric treatment or antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		45. concentration problems or ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>		46. alcohol/recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>				
12. prolonged bleeding due to slight cut (INR >3.5)	<input type="checkbox"/>	<input type="checkbox"/>				
13. pneumonia, emphysema, shortness of breath, sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>				
14. chronic ear infections, tuberculosis, measles, chicken pox	<input type="checkbox"/>	<input type="checkbox"/>				
15. breathing problems (e.g. asthma, stuffy nose)	<input type="checkbox"/>	<input type="checkbox"/>				
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting)	<input type="checkbox"/>	<input type="checkbox"/>				
17. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>				
18. liver disease or jaundice	<input type="checkbox"/>	<input type="checkbox"/>				
19. vertigo (e.g. "The room is spinning")	<input type="checkbox"/>	<input type="checkbox"/>				
20. thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>				

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## MEDICAL HISTORY (CONT'D.)

**ARE YOU:**

	YES	NO		YES	NO
47. presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy/sensitive person	<input type="checkbox"/>	<input type="checkbox"/>
48. aware of a change in your health in the last 24 hours (e.g. fever, chills, new cough, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
49. taking medication for weight management	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
50. taking dietary supplements, vitamins, probiotics	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
51. often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>	58. diagnosed with a prostate disorder	<input type="checkbox"/>	<input type="checkbox"/>
52. experiencing frequent headaches or chronic pain	<input type="checkbox"/>	<input type="checkbox"/>			
53. a smoker, smoked previously, or other (smokeless tobacco, vaping, e-cigarettes, cannabis)	<input type="checkbox"/>	<input type="checkbox"/>			

**Do you require premedication prior to your dental appointment? YES:  NO:**

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):

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List all medications, supplements, and/or vitamins taken within the last two years:

**Drug:**

**Purpose:**

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**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 \_\_\_\_\_