

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 _____	<input type="checkbox"/>	<input type="checkbox"/>	27. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following: <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine <input type="checkbox"/> penicillin <input type="checkbox"/> erythromycin <input type="checkbox"/> tetracycline <input type="checkbox"/> sulfa <input type="checkbox"/> local anesthetic <input type="checkbox"/> fluoride <input type="checkbox"/> chlorhexidine (CHX) <input type="checkbox"/> metals (nickel, gold, silver, _____) <input type="checkbox"/> latex _____ <input type="checkbox"/> nuts _____ <input type="checkbox"/> fruit _____ <input type="checkbox"/> milk _____ <input type="checkbox"/> red dye _____ <input type="checkbox"/> other _____	<input type="checkbox"/>	<input type="checkbox"/>	28. arthritis or gout _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	29. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	30. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	31. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	32. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____	<input type="checkbox"/>	<input type="checkbox"/>	33. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
8. heart murmur, rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	34. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	35. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
10. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	36. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
11. stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	37. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
12. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	38. STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
13. prolonged bleeding due to a slight cut (or INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	39. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
14. pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
15. chronic ear infections, tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	41. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
17. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
18. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment or antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
19. liver disease or jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	45. concentration problems or ADD/ADHD diagnosis _____	<input type="checkbox"/>	<input type="checkbox"/>
20. vertigo (e.g. "the room is spinning") _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
21. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
22. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
23. high cholesterol or taking statin drugs _____	<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, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
24. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
25. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
26. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<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, and cannabis) _____	<input type="checkbox"/>	<input type="checkbox"/>
			54. considered atouchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
			55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
			56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
			57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
			58. diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>

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

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 _____