

# 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

| <b>DO YOU HAVE or HAVE YOU EVER HAD:</b>                     | <b>YES</b>               | <b>NO</b>                |   | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____               | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to                                   |                          |                          | 27. arthritis _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen   |                          |                          | 28. glaucoma _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin                          |                          |                          | 29. contact lenses _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin                        |                          |                          | 30. head or neck injuries _____                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline                        |                          |                          | 31. epilepsy, convulsions (seizures) _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> codeine                             |                          |                          | 32. neurologic problems _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic                    |                          |                          | 33. viral infections and cold sores _____                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride                            |                          |                          | 34. any lumps or swelling in the mouth _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (gold, stainless steel)      |                          |                          | 35. hives, skin rash, hay fever _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex                               |                          |                          | 36. venereal disease _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> any other medications _____         |                          |                          | 37. hepatitis (type ___) _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems _____                                      | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. heart murmur _____  | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. rheumatic fever _____                                     | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. scarlet fever _____                                       | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. high blood pressure _____                                 | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. low blood pressure _____                                  | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a stroke _____  | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. artificial prosthesis (i.e. heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / drug dependency _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____                     | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 12. prolonged bleeding due to a slight cut _____             | <input type="checkbox"/> | <input type="checkbox"/> | <b>ARE YOU:</b>   |                          |                          |
| 13. emphysema _____  | <input type="checkbox"/> | <input type="checkbox"/> | 46. presently being treated for any other illness _____           | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis _____                                       | <input type="checkbox"/> | <input type="checkbox"/> | 47. aware of a change in your general health _____                | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____   | <input type="checkbox"/> | <input type="checkbox"/> | 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking dietary supplements _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____                                     | <input type="checkbox"/> | <input type="checkbox"/> | 50. often exhausted or fatigued _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____                                      | <input type="checkbox"/> | <input type="checkbox"/> | 51. subject to frequent headaches _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____   | <input type="checkbox"/> | <input type="checkbox"/> | 52. a smoker or smoked previously _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid or parathyroid disease _____                     | <input type="checkbox"/> | <input type="checkbox"/> | 53. considered a touchy person _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____                                 | <input type="checkbox"/> | <input type="checkbox"/> | 54. often unhappy or depressed _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol _____                                   | <input type="checkbox"/> | <input type="checkbox"/> | 55. FEMALE - taking birth control pills _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes _____   | <input type="checkbox"/> | <input type="checkbox"/> | 56. FEMALE - pregnant _____                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____                          | <input type="checkbox"/> | <input type="checkbox"/> | 57. MALE - prostate disorders _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. gastric reflux) _____          | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

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

| Drug  | Purpose | Drug  | Purpose |
|-------|---------|-------|---------|
| _____ | _____   | _____ | _____   |
| _____ | _____   | _____ | _____   |
| _____ | _____   | _____ | _____   |

Ask for an additional sheet if you are taking more than 6 medications

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