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
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. poly cystic 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:

		YES	NO
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 ______________

ASA ______ **(1-6)**

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