

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**

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. hospitalization for illness or injury _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 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 _____ 3. heart problems, or cardiac stent within the last six months _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 4. history of infective endocarditis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 5. artificial heart valve, repaired heart defect (PFO) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 6. pacemaker or implantable defibrillator _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 8. heart murmur, rheumatic or scarlet fever _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 9. high or low blood pressure _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 10. a stroke (taking blood thinners) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 11. anemia or other blood disorder _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 12. prolonged bleeding due to a slight cut (or INR > 3.5) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 13. pneumonia, emphysema, shortness of breath, sarcoidosis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 14. chronic ear infections, tuberculosis, measles, chicken pox _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 17. kidney disease _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 18. liver disease or jaundice _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 19. vertigo (e.g. "the room is spinning") _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 20. thyroid, parathyroid disease, or calcium deficiency _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 22. high cholesterol or taking statin drugs _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 23. diabetes (HbA1c = _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 24. stomach or duodenal ulcer _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO | <ol style="list-style-type: none"> 26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 27. arthritis or gout _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 28. autoimmune disease
(e.g. rheumatoid arthritis, lupus, scleroderma) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 29. glaucoma _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 30. contact lenses _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 31. head or neck injuries _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 32. epilepsy, convulsions (seizures) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 33. neurologic disorders (ADD/ADHD, prion disease) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 34. viral infections and cold sores _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 35. any lumps or swelling in the mouth _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 36. hives, skin rash, hay fever _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 37. STI/STD/HPV _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 38. hepatitis (type _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 39. HIV/AIDS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 40. tumor, abnormal growth _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 41. radiation therapy _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 42. chemotherapy, immunosuppressive medication _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 43. emotional difficulties _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 44. psychiatric treatment or antidepressant medication _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 45. concentration problems or ADD/ADHD diagnosis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 46. alcohol/recreational drug use _____ <input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|---|

ARE YOU:

- | |
|---|
| <ol style="list-style-type: none"> 47. presently being treated for any other illness _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 48. aware of a change in your health in the last 24 hours
(e.g., fever, chills, new cough, or diarrhea) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 49. taking medication for weight management _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 50. taking dietary supplements _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 51. often exhausted or fatigued _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 52. experiencing frequent headaches or chronic pain _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 53. a smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, and cannabis) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 54. considered a touchy/sensitive person _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 55. often unhappy or depressed _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 56. taking birth control pills _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 57. currently pregnant _____ <input type="checkbox"/> YES <input type="checkbox"/> NO 58. diagnosed with a prostate disorder _____ <input type="checkbox"/> YES <input type="checkbox"/> 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) _____

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 _____