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

HAVE YOU EVER HAD THE FOLLOWING?	YES	NO
1. Hospitalization for major illness or injury	❒	❒
2. Allergic reaction to:		
❒ aspirin, ibuprofen, acetaminophen		
❒ penicillin		
❒ erythromycin		
❒ codeine		
❒ local anesthetic		
❒ fluoride		
❒ metals (gold, stainless steel)		
❒ latex		
❒ any other medications		
3. heart problems	❒	❒
4. heart murmur	❒	❒
5. rheumatic fever	❒	❒
6. scarlet fever	❒	❒
7. high blood pressure	❒	❒
8. low blood pressure	❒	❒
9. a stroke	❒	❒
10. artificial prosthesis (i.e. heart valve or joints)	❒	❒
11. anemia or other blood disorder	❒	❒
12. Have you ever bled excessively after being cut or injured?	❒	❒
13. emphysema	❒	❒
14. tuberculosis	❒	❒
15. asthma/inhaler	❒	❒
16. sinus problems	❒	❒
17. kidney disease	❒	❒
18. liver disease or jaundice	❒	❒
19. thyroid or parathyroid disease	❒	❒
20. hormone deficiency	❒	❒
21. high cholesterol	❒	❒
22. diabetic? Insulin dependant?	❒	❒
23. stomach or duodenal ulcer	❒	❒
24. digestive disorders	❒	❒
25. arthritis	❒	❒
26. glaucoma	❒	❒
27. contact lens	❒	❒
28. head or neck injuries	❒	❒
29. epilepsy, convulsions (seizures)	❒	❒
30. viral infections and cold sores	❒	❒
31. any lumps or swelling in the mouth	❒	❒
32. venereal disease or STD	❒	❒
33. Hepatitis (type____)	❒	❒
34. HIV	❒	❒
35. AIDS	❒	❒
36. tumor, abnormal growth	❒	❒
37. radiation therapy	❒	❒
38. chemotherapy	❒	❒
39. psychiatric treatment	❒	❒
40. alcohol/drug dependency	❒	❒
41. Do you smoke, chew, use snuff or any other forms of tobacco?	❒	❒
42. Do you regularly consume more than one or two alcoholic beverages a day?	❒	❒
ARE YOU		
43. presently being treated for any other illness	❒	❒
44. aware of any change in your general health	❒	❒
45. taking medication for osteoporosis / osteopenia	❒	❒
46. often exhausted or fatigued	❒	❒
47. subject to frequent headaches	❒	❒
48. FEMALE: taking birth control pills	❒	❒
49. FEMALE: pregnant	❒	❒

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

_____

List any medications, supplements, and or vitamins taken with in 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 MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ **Date** _____

Doctor's Signature _____ Date _____