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 reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ 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. prolonged bleeding due to a slight cut _____	◯	◯
13. emphysema _____	◯	◯
14. tuberculosis _____	◯	◯
15. asthma _____	◯	◯
16. breathing or sleep problems (i.e. snoring, sinus)_____	◯	◯
17. kidney disease _____	◯	◯
18. liver disease _____	◯	◯
19. jaundice _____	◯	◯
20. thyroid or parathyroid disease _____	◯	◯
21. hormone deficiency _____	◯	◯
22. high cholesterol _____	◯	◯
23. diabetes _____	◯	◯
24. stomach or duodenal ulcer _____	◯	◯
25. digestive disorders (i.e. gastric reflux)_____	◯	◯

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	◯	◯
27. arthritis _____	◯	◯
28. glaucoma_____	◯	◯
29. contact lenses _____	◯	◯
30. head or neck injuries _____	◯	◯
31. epilepsy, convulsions (seizures) _____	◯	◯
32. neurologic problems _____	◯	◯
33. viral infections and cold sores _____	◯	◯
34. any lumps or swelling in the mouth_____	◯	◯
35. hives, skin rash, hay fever_____	◯	◯
36. venereal disease _____	◯	◯
37. hepatitis (type ___) _____	◯	◯
38. HIV / AIDS _____	◯	◯
39. tumor, abnormal growth_____	◯	◯
40. radiation therapy_____	◯	◯
41. chemotherapy_____	◯	◯
42. emotional problems _____	◯	◯
43. psychiatric treatment_____	◯	◯
44. antidepressant medication _____	◯	◯
45. alcohol / drug dependency _____	◯	◯
ARE YOU:		
46. presently being treated for any other illness _____	◯	◯
47. aware of a change in your general health _____	◯	◯
48. taking medication for weight management (i.e. fen-phen)	◯	◯
49. taking dietary supplements_____	◯	◯
50. often exhausted or fatigued _____	◯	◯
51. subject to frequent headaches _____	◯	◯
52. a smoker or smoked previously _____	◯	◯
53. considered a touchy person _____	◯	◯
54. often unhappy or depressed_____	◯	◯
55. FEMALE - taking birth control pills _____	◯	◯
56. FEMALE - pregnant _____	◯	◯
57. MALE - prostate disorders _____	◯	◯

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 _____