

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 illness or injury.....
- 2. 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. sinus problems.....
- 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.....

- | | YES | NO |
|---|--------------------------|--------------------------|
| 25. digestive disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. contact lenses..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. head or neck injuries..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. epilepsy, convulsions (seizures)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. viral infections and cold sores..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. any lumps or swelling in the mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. hives, skin rash, hay fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. venereal disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. hepatitis (type ____)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. HIV / AIDS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. tumor, abnormal growth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. radiation therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. chemotherapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. emotional problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. psychiatric treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. antidepressant medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. alcohol / drug dependency..... | <input type="checkbox"/> | <input type="checkbox"/> |

ARE YOU:

- 44. presently being treated for any other illness.....
- 45. aware of a change in your general health.....
- 46. taking medication for osteoporosis/osteopenia ..
- 47. often exhausted or fatigued.....
- 48. subject to frequent headaches.....
- 49. a heavy smoker (1 pack or more a day).....
- 50. considered a touchy person.....
- 51. often unhappy or depressed.....
- 52. easily upset or irritated.....
- 53. FEMALE - taking birth control pills.....
- 54. FEMALE - pregnant.....
- 55. MALE - Prostate disorders.....

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 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 _____

