MEDICAL HISTORY

Patient Name_____ Preferred Name_____ 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, ibuprophen, acetaminophen, codeine	____	____
Penicillin _____	____	____
Erythromycin _____	____	____
Tetracycline _____	____	____
Sulpha _____	____	____
Local anesthetic _____	____	____
Fluoride _____	____	____
Metals (nickel, gold, silver)_____	____	____
Latex _____	____	____
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. Artificial prostheses (heart valve or joints)_____	____	____
8. Rheumatic or scarlet fever _____	____	____
9. High blood pressure _____	____	____
10. Low blood pressure_____	____	____
11. A stroke (taking blood thinners)_____	____	____
12. Anemia or other blood disorder _____	____	____
13. Prolonged bleeding due to a slight cut (INR>3.5)____	____	____
14. Emphysema, sarcoidosis_____	____	____
15. Tuberculosis _____	____	____
16. Asthma_____	____	____
17. Snoring /Sleep problems _____	____	____
18. Use a CPAP or other sleep aid _____	____	____
19. Kidney disease _____	____	____
20. Liver disease _____	____	____
21. Jaundice_____	____	____
22. Thyroid, parathyroid disease, or calcium deficiency	____	____
23. Hormone deficiency _____	____	____
24. High cholesterol _____	____	____
25. Diabetes (HbA1c=_____) _____	____	____
26. Stomach or duodenal ulcer _____	____	____

	YES	NO
27. Digestive disorders (i.e. gastric reflux) _____	____	____
28. Osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	____	____
29. Arthritis _____	____	____
30. Glaucoma _____	____	____
31. Contact lenses _____	____	____
32. Head or neck injuries _____	____	____
33. Epilepsy, convulsions (seizures) _____	____	____
34. Hives, skin rash, hay fever _____	____	____
35. Venereal disease _____	____	____
36. Hepatitis (type___) _____	____	____
37. HIV/AIDS_____	____	____
38. Tumor, abnormal growth _____	____	____
39. Radiation therapy_____	____	____
40. Chemotherapy_____	____	____
41. Emotional problems _____	____	____
42. Psychiatric treatment _____	____	____
43. Antidepressant or anxiety medications _____	____	____
44. Alcohol/drug dependency _____	____	____
ARE YOU:		
45. Presently being treated for any other illness _____	____	____
46. Aware of a change in your general health _____	____	____
47. Taking medication for weight management (i.e. fen-phen) ____	____	____
48. Taking dietary supplements _____	____	____
49. Often exhausted or fatigued _____	____	____
50. Subject to frequent headaches _____	____	____
51. A smoker_____	____	____
52. Smoked previously _____	____	____
53. Often unhappy or depressed _____	____	____
54. FEMALE- taking birth control pills _____	____	____
55. FEMALE- pregnant _____	____	____
56. MALE-prostate disorder _____	____	____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature_____ Date _____