FIRST HILL DENTAL CENTER

Medical History Form

Patient Name
Nickname
Age
Name of Physician/and their specialty
Most recent physical examination
Purpose
What is your estimate of your general health?
Please choose from the following: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
1. HAVE YOU EVER HAD AN ALLERGIC REACTION TO: ❑ (a) aspirin, ibuprofen, acetaminophen, codeine ❑ (b) penicillin ❑ (c) erythromycin ❑ (d) tetracycline ❑ (e) sulfa ❑ (f) local anesthetic ❑ (g) fluoride ❑ (h) metals (nickel, gold, silver, other) ❑ (i) latex ❑ (j) other
DO YOU HAVE or HAVE YOU EVER HAD: ❑ 2. hospitalization for illness or injury ❑ 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 prosthesis (heart valve or joints) ❑ 8. rheumatic or scarlet fever ❑ 9. high or low blood pressure ❑ 10. a stroke (taking blood thinners) ❑ 11. anemia or other blood disorder ❑ 12. prolonged bleeding due to a slight cut (INR3.5) ❑ 13. emphysema, shortness of breath, sarcoidosis ❑ 14. tuberculosis, measels, chicken pox ❑ 15. asthma ❑ 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ❑ 17. kidney disease ❑ 18. liver disease ❑ 19. jaundice ❑ 20. thyroid, parathyroid disease, or calcium deficiency ❑ 21. hormone deficiency ❑ 22. high cholesterol or taking statin drugs ❑ 23. diabetes (HbA1c: ____) ❑ 24. stomach or duodenal ulcer ❑ 25. digestive disorders (i.e. gastric reflux) ❑ 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ❑ 27. arthritis, rheumatoid arthritis, lupus ❑ 28. glaucoma ❑ 29. contact lenses

DO YOU HAVE or HAVE YOU EVER HAD:

- ❑ 30. head or neck injuries
- ❑ 31. epilepsy, convulsions (seizures)
- ❑ 32. neurologic disorders (ADD/ADHD, prion disease)
- ❑ 33. viral infections and cold sores
- ❑ 34. any lumps or swelling in the mouth
- ❑ 35. hives, skin rash, hay fever
- ❑ 36. STI/STD
- ❑ 37. hepatitis (type ___)
- ❑ 38. HIV / AIDS
- ❑ 39. tumor, abnormal growth
- ❑ 40. radiation therapy
- ❑ 41. chemotherapy, immunosuppressive
- ❑ 42. emotional problems
- ❑ 43. psychiatric treatment
- ❑ 44. antidepressant medication
- ❑ 45. alcohol / street drug use

ARE YOU:

- ❑ 46. presently being treated for any other illness
- ❑ 47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, diarrhea)
- ❑ 48. taking medication for weight management (i.e. fen-phen)
- ❑ 49. taking dietary supplements
- ❑ 50. often exhausted or fatigued
- ❑ 51. experiencing frequent headaches
- ❑ 52. a smoker, smoked previously or use smokeless tobacco
- ❑ 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. (i.e. Botox, Collagen Injections)

Please describe:

List all medications, supplements, and or vitamins taken within the last two years

(a) Drug	(b) 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: