MEDICAL HISTORY FORM

Name:	Age:
Name of Physician:	Most recent physical exam:
What is the estimate of your general health:	☐ Excellent ☐ Good ☐ Fair ☐ Poor

HAVE YOU EVER HAD AN ALLERGIC REACTION TO:

☐ Aspirin, ibuprofen, acetaminophen, codeine	☐ Penicillin
☐ Erythromycin	☐ Tetracycline
☐ Sulfa	☐ Local Anesthetic
☐ Fluoride	☐ Metals (nickel, gold, silver, other)
☐ Latex	☐ Other:

DO YOU HAVE or HAVE YOU EVER HAD:

☐ Hospitalization for illness or injury	☐ Heart problems or cardiac stent within the last six months
☐ History of infective endocarditis	☐ Artificial heart valve, repaired heart defect (PFO)
☐ Pacemaker or implantable defibrillator	☐ Artificial prosthesis (heart valve or joints)
☐ Rheumatic or scarlet fever	☐ High or low blood pressure
☐ A stroke (taking blood thinners)	☐ Anemia or other blood disorder
☐ Prolonged bleeding due to a slight cut (INR3.5)	☐ Emphysema, shortness or breath, sarcoidosis
☐ Tuberculosis, measles, chicken pox	☐ Asthma
☐ Kidney disease	☐ Breathing or sleep problems (i.e. sleep apnea, snoring, sinus
☐ Liver disease	☐ Jaundice
☐ Thyroid, parathyroid disease, or calcium deficiency	☐ Hormone deficiency
☐ High cholesterol or taking statin drugs	☐ Diabetes (HbA1c:_____)
☐ Stomach or duodenal ulcer	☐ Digestive disorders (i.e. gastric reflux)
☐ Glaucoma	☐ Osteoporosis/osteopenia (i.e. taking bisphosphonates)
☐ Arthritis, rheumatoid arthritis, lupis	☐ Alcohol/ street drug use
☐ Contact lenses	☐ Head or neck injuries
☐ Epilepsy, convulsions (seizures)	☐ Neurologic disorders (ADD/ADHD, prion disease)
☐ Viral infections and cold sores	☐ Any lumps or swelling in the mouth
☐ Hives, skin rash, hay fever	☐ STI/STD
☐ Hepatitis (Type ____)	☐ HIV/AIDS
☐ Tumor, abnormal growth	☐ Radiation therapy
☐ Emotional problems	☐ Chemotherapy, immunosuppressive
☐ Psychiatric treatment	☐ Antidepressant medication

ARE YOU:

☐ Presently being treated for any other illness	☐ Aware of a change in your health in the last 24 hours
☐ Taking dietary supplements	☐ Taking medications for weight management (i.e. fen-phen)
☐ Often exhausted or fatigued	☐ Experiencing frequent headaches
☐ Considered a touchy person	☐ A smoker, smoked previously, or use smokeless tobacco
☐ Often unhappy or depressed	☐ FEMALE – taking birth control pills
☐ MALE – prostate disorders	☐ FEMALE – pregnant

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 in the last two years:

Drug:	Purpose:

_____

Signature (responsible party) Date

_____

Doctors Signature Date