MEDICAL HISTORY

Patient Name Nickname DOB Name of Physician/and their specialty (list all) 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 YES NO

1. list all hospitalizations for illness or injury
2. an allergic or bad reaction to any of the following: aspirin, ibuprofen, acetaminophen, codeine penicillin erythromycin tetracycline sulfa local anesthetic fluoride chlorhexidine (CHX) Iodine metals (nickel, gold, silver, ) latex nuts fruit milk red dye other

1. heart problems, or cardiac stent within the last six months
2. history of infective endocarditis
3. artificial heart valve, repaired heart defect (PFO)
4. pacemaker or implantable defibrillator
5. orthopedic or soft tissue implant (e.g joint replacement, breast implant)
6. heart murmur, rheumatic or scarlet fever
7. high or low blood pressure
8. a stroke (taking blood thinners)
9. anemia or other blood disorder
10. prolonged bleeding due to a slight cut (or INR > 3.5)
11. pneumonia, emphysema, shortness of breath, sarcoidosis
12. chronic ear infections, tuberculosis, measles, chicken pox
13. breathing problems (e.g. asthma, stuffy nose, sinus congestion)
14. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting)
15. kidney disease
16. liver disease or jaundice
17. vertigo (e.g.” the room is spinning”)
18. thyroid, parathyroid disease, or calcium deficiency
19. hormone deficiency or imbalance (e.g., poly cystic ovarian syndrome)
20. high cholesterol or taking statin drugs.
21. diabetes (HbA1c = )
22. stomach or duodenal ulcer
23. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)
24. osteoporosis/osteopenia or ever taken anti-resorptive   medications (e.g., bisphosphonates)
25. arthritis or gout
26. autoimmune disease

(e.g., rheumatoid arthritis, lupus, scleroderma)

1. glaucoma
2. contact lenses.
3. head or neck injuries
4. epilepsy, convulsions (seizures)
5. neurologic disorders (e.g., Alzheimer’s disease, dementia, prion disease)
6. viral infections and cold sores
7. any lumps or swelling in the mouth.
8. hives, skin rash, hay fever
9. STI/STD/HPV
10. hepatitis (type )
11. HIV/AIDS
12. tumor, abnormal growth
13. radiation therapy
14. chemotherapy, immunosuppressive medication
15. emotional difficulties
16. psychiatric treatment or antidepressant medication
17. concentration problems or ADD/ADHD
18. alcohol/recreational drug use

# ARE YOU:

1. presently being treated for any other illness
2. aware of a change in your health in the last 24 hours

(e.g., fever, chills, new cough, or diarrhea)

1. taking medication for weight management
2. taking dietary supplements, vitamins, and/or probiotics
3. often exhausted or fatigued.
4. experiencing frequent headaches or chronic pain
5. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis)
6. considered a touchy/sensitive person.
7. often unhappy or depressed
8. taking birth control pills
9. currently pregnant
10. diagnosed with a prostate disorder.

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) Please list ALL

List all medications, supplements, vitamins, and/or probiotics 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

Doctor’s Signature

Date

Date