MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Date of 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 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 ☐ fruit ☐ red dye
☐ nuts ☐ milk
☐ 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.	orthopedic or soft tissue implant (e.g. joint replacement, breast implant)	☐	☐
8.	heart murmur, 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 (or INR > 3.5)	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15.	breathing problems (e.g. asthma, stuffy nose, sinus congestion)	☐	☐
16.	sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
17.	kidney disease	☐	☐
18.	liver disease or jaundice	☐	☐
19.	vertigo (e.g. "the room is spinning")	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency	☐	☐
21.	hormone deficiency or imbalance (e.g. polycystic ovarian syndrome)	☐	☐
22.	high cholesterol or taking statin drugs	☐	☐
23.	diabetes (HbA1c = _____)	☐	☐
24.	stomach or duodenal ulcer	☐	☐
25.	digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)	☐	☐
27.	arthritis or gout	☐	☐
28.	autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	glaucoma	☐	☐
30.	contact lenses	☐	☐
31.	head or neck injuries	☐	☐
32.	epilepsy, convulsions (seizures)	☐	☐

33.	neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease)	☐	☐
34.	viral infections and cold sores	☐	☐
35.	any lumps or swelling in the mouth	☐	☐
36.	hives, skin rash, hay fever	☐	☐
37.	STI/STD/HPV	☐	☐
38.	hepatitis (type _____)	☐	☐
39.	HIV/AIDS	☐	☐
40.	tumor, abnormal growth	☐	☐
41.	radiation therapy	☐	☐
42.	chemotherapy, immunosuppressive medication	☐	☐
43.	emotional difficulties	☐	☐
44.	psychiatric treatment or antidepressant medication	☐	☐
45.	concentration problems or ADD/ADHD	☐	☐
46.	alcohol/recreational drug use: frequency _____ amount _____	☐	☐

ARE YOU:		**YES**	**NO**
47.	presently being treated for any other illness	☐	☐
48.	aware of a change in your health in the last 24 hours	☐	☐
49.	taking medication for weight management	☐	☐
50.	taking dietary supplements, vitamins, and/or probiotics	☐	☐
51.	often exhausted or fatigued	☐	☐
52.	experiencing frequent headaches or chronic pain	☐	☐
53.	a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis): frequency _____ amount _____	☐	☐
54.	considered a touchy/sensitive person	☐	☐
55.	often unhappy or depressed	☐	☐
56.	taking birth control pills	☐	☐
57.	currently pregnant	☐	☐
58.	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) _____

_____

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 _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6) ☐ ☐ ☐