

MEDICAL HISTORY

Patient Name _____ Nickname _____ 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 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 _____

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, nasal breathing, 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., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____

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 (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____

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. difficulties with stress management _____

44. psychiatric treatment, antidepressants, mood stabilizing medications _____

45. concentration problems or ADD/ADHD _____

46. alcohol/recreational drug use _____

YES

NO

47. presently being treated for any other illness _____

48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____

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) _____

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 _____

ARE YOU:

YES

NO

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 _____

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ASA _____ (1-6) 

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