

# 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 YES NO

- |   |                          |                          |   |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____  | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic or bad reaction to any of the following:<br><input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____<br><input type="checkbox"/> penicillin _____<br><input type="checkbox"/> erythromycin _____<br><input type="checkbox"/> tetracycline _____<br><input type="checkbox"/> sulfa _____<br><input type="checkbox"/> local anesthetic _____<br><input type="checkbox"/> fluoride _____<br><input type="checkbox"/> chlorhexidine (CHX) _____<br><input type="checkbox"/> iodine _____<br><input type="checkbox"/> metals (nickel, gold, silver, _____)<br><input type="checkbox"/> latex _____<br><input type="checkbox"/> nuts _____<br><input type="checkbox"/> fruit _____<br><input type="checkbox"/> milk _____<br><input type="checkbox"/> red dye _____<br><input type="checkbox"/> other _____ | <input type="checkbox"/> | <input type="checkbox"/> | 27. arthritis or gout _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____  | <input type="checkbox"/> | <input type="checkbox"/> | 28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____  | <input type="checkbox"/> | <input type="checkbox"/> | 29. glaucoma _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 30. contact lenses _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____   | <input type="checkbox"/> | <input type="checkbox"/> | 31. head or neck injuries _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____   | <input type="checkbox"/> | <input type="checkbox"/> | 32. epilepsy, convulsions (seizures) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. heart murmur, rheumatic or scarlet fever _____   | <input type="checkbox"/> | <input type="checkbox"/> | 33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____   | <input type="checkbox"/> | <input type="checkbox"/> | 34. viral infections and cold sores _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 35. any lumps or swelling in the mouth _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____  | <input type="checkbox"/> | <input type="checkbox"/> | 36. hives, skin rash, hay fever _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut (or INR > 3.5) _____   | <input type="checkbox"/> | <input type="checkbox"/> | 37. STI/STD/HPV _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. pneumonia, emphysema, shortness of breath, sarcoidosis _____  | <input type="checkbox"/> | <input type="checkbox"/> | 38. hepatitis (type _____) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. chronic ear infections, tuberculosis, measles, chicken pox _____  | <input type="checkbox"/> | <input type="checkbox"/> | 39. HIV/AIDS _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____   | <input type="checkbox"/> | <input type="checkbox"/> | 40. tumor, abnormal growth _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 41. radiation therapy _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____  | <input type="checkbox"/> | <input type="checkbox"/> | 42. chemotherapy, immunosuppressive medication _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease or jaundice _____   | <input type="checkbox"/> | <input type="checkbox"/> | 43. emotional difficulties _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. vertigo (e.g. "the room is spinning") _____   | <input type="checkbox"/> | <input type="checkbox"/> | 44. psychiatric treatment or antidepressant medication _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____   | <input type="checkbox"/> | <input type="checkbox"/> | 45. concentration problems or ADD/ADHD _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 46. alcohol/recreational drug use _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 23. diabetes (HbA1c = _____) _____  | <input type="checkbox"/> | <input type="checkbox"/> | <b>ARE YOU:</b>   |                          |                          |
| 24. stomach or duodenal ulcer _____   | <input type="checkbox"/> | <input type="checkbox"/> | 47. presently being treated for any other illness _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 49. taking medication for weight management _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 50. taking dietary supplements, vitamins, and/or probiotics _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 51. often exhausted or fatigued _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 52. experiencing frequent headaches or chronic pain _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 54. considered a touchy/sensitive person _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 55. often unhappy or depressed _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 56. taking birth control pills _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 57. currently pregnant _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 58. diagnosed with a prostate disorder _____  | <input type="checkbox"/> | <input type="checkbox"/> |

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 \_\_\_\_\_