MEDICAL HISTORY

Patient Name_____ DOB_____

Name of Physician and Specialty_____

Date of most recent physical exam_____Purpose_____

What is your estimate of your general health? ❑Excellent ❑ Good ❑ Fair ❑ Poor

DO YOU HAVE, OR HAVE YOU EVER HAD:	**YES**	**NO**
Hospitalization for illness or injury	❑	❑
An allergic to reaction to:		
❑Aspirin, Ibuprofen, acetaminophen, codeine		
❑Penicillin		
❑Erythromycin		
❑Tetracycline		
❑Sulfa		
❑Local anesthetic		
❑Latex		
❑Metals (nickel, gold, silver, _____)		
❑Other		
Heart problems or cardiac stent	❑	❑
History of infective endocarditis	❑	❑
Artificial heart valve, repaired heart defect	❑	❑
Pacemaker/defibrillator	❑	❑
Artificial prosthesis (joint replacement)	❑	❑
Rheumatic or scarlet fever	❑	❑
High or low blood pressure	❑	❑
Stroke	❑	❑
Anemia or other blood disorder	❑	❑
Prolonged bleeding/ poor clotting	❑	❑
Emphysema, sarcoidosis	❑	❑
Tuberculosis	❑	❑
Asthma	❑	❑
Breathing problems (sinus, apnea)	❑	❑
Kidney disease	❑	❑
Liver disease	❑	❑
Jaundice	❑	❑
Thyroid/parathyroid disease	❑	❑
Hormone deficiency	❑	❑
High cholesterol or taking statin drugs	❑	❑
Diabetes (type_____)	❑	❑
Stomach or duodenal ulcer	❑	❑
Digestive disorders (GERD)	❑	❑

	YES	**NO**
Osteoporosis/osteopenia	❑	❑
Arthritis	❑	❑
Glaucoma	❑	❑
Contact lenses	❑	❑
Head or neck injuries	❑	❑
Epilepsy, convulsions, seizures	❑	❑
Neurologic problems (ADD)	❑	❑
Herpes and/or cold sores	❑	❑
Lumps or swelling in the mouth	❑	❑
Hives, skin rash, hayfever	❑	❑
Venereal disease	❑	❑
Hepatitis (type___)	❑	❑
HIV/ AIDS	❑	❑
Tumor, abnormal growth	❑	❑
Radiation therapy	❑	❑
Chemotherapy	❑	❑
Emotional problems	❑	❑
Psychiatric treatment	❑	❑
Antidepressant medication	❑	❑
Alcohol/ drug dependency	❑	❑

ARE YOU:	**YES**	**NO**
Being treated for any illness	❑	❑
Aware of a change in your health	❑	❑
Taking dieting medication (fen-fen)	❑	❑
Taking dietary supplements	❑	❑
Often exhausted or fatigued	❑	❑
Subject to frequent headaches	❑	❑
A smoker or ex-smoker	❑	❑
Considered a touchy person	❑	❑
Often unhappy or depressed	❑	❑
FEMALE –taking birth control pills	❑	❑
FEMALE- pregnant	❑	❑
MALE- prostrate disorders	❑	❑

Describe any medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements or vitamins taken within the last two years on the back of this sheet.

Patient's signature_____Date_____

Doctor's signature:_____Date_____

PLEASE LIST ALL MEDICATIONS, SUPPLEMENTS OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS

DRUG/VITAMIN	PURPOSE	DATE LAST TAKEN

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICATION OR MEDICAL HISTORY