MEDICAL HISTORY

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we are happy to help.

Name _____ Nickname _____ Birthdate _____

Primary Care Physician _____

Most Recent Physical Exam _____ Purpose _____

What is your perception of your general health condition? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE, OR HAVE YOU EVER HAD:

		Yes	No
1.	Hospitalization for illness or injury? If yes, why?	☐	☐
2.	An allergic or bad reaction to:		
	Aspirin, ibuprofen, acetaminophen, codeine	☐	☐
	Penicillin	☐	☐
	Erythromycin	☐	☐
	Tetracycline	☐	☐
	Sulfa	☐	☐
	Local anesthetic	☐	☐
	Fluoride	☐	☐
	Chlorhexidine (CHX)	☐	☐
	Metals-nickel, gold, silver, other :	☐	☐
	Latex	☐	☐
	Food-nuts, fruits, other:	☐	☐
	Other:	☐	☐
3.	Heart problems/cardiac stent in the last 6 months	☐	☐
4.	History of infective endocarditis	☐	☐
5.	Artificial heart valve, repaired heart defect (PFO)	☐	☐
6.	Pacemaker or implantable defibrillator	☐	☐
7.	Orthopedic Implant (joint replacement)	☐	☐
8.	Genetic Disorder or Disease	☐	☐
9.	High or low blood pressure	☐	☐
10.	Stroke or taking blood thinners	☐	☐
11.	Anemia or other blood disorder	☐	☐
12.	Prolonged bleeding due to a slight cut (INR>3.0)	☐	☐
13.	Pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14.	Chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15.	Asthma	☐	☐
16.	Breathing/sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17.	Kidney disease	☐	☐
18.	Liver disease	☐	☐
19.	Jaundice	☐	☐

		Yes	No
20.	Thyroid, parathyroid disease, or calcium deficiency	☐	☐
21.	Hormone deficiency	☐	☐
22.	High cholesterol or taking statin drugs	☐	☐
23.	Diabetes - HbA1c= (Enter Level)	☐	☐
24.	Stomach or duodenal ulcer	☐	☐
25.	Digestive or eating disorder (e.g. celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26.	Osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27.	Arthritis	☐	☐
28.	Autoimmune disease (Rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	Glaucoma	☐	☐
30.	Head or neck injuries	☐	☐
31.	Epilepsy, convulsions (seizures)	☐	☐
32.	Neurologic disorders (ADD/ADHD, prion disease)	☐	☐
33.	Viral infections and cold sores	☐	☐
34.	Any lumps or swelling in the mouth	☐	☐
35.	Hives, skin rash, hay fever	☐	☐
36.	STI / STD / HPV	☐	☐
37.	Hepatitis – Type: (Enter Type)	☐	☐
38.	HIV / AIDS	☐	☐
39.	Cancer, tumor or abnormal growth	☐	☐
	Radiation Therapy	☐	☐
	Chemotherapy, immunosuppressive medication	☐	☐
40.	Emotional difficulties	☐	☐
41.	Psychiatric treatment	☐	☐
42.	Antidepressant medication	☐	☐
43.	Alcohol / recreational drug use	☐	☐
	If so, how frequently? ___ times a day ___ times a week	☐	☐
44.	Being treated for any other illness?	☐	☐

Continued

	ARE YOU:	Yes	No
45.	Aware of any change in your health in the last 24 hours (fever, chills, new cough or diarrhea)	☐	☐
46.	Taking medication for weight management	☐	☐
47.	Taking dietary supplements	☐	☐
48.	Often exhausted or fatigued	☐	☐
49.	Experiencing frequent headaches	☐	☐
50.	A smoker, smoked previously, or use smokeless tobacco	☐	☐
	If so, how frequently? ___ times a day ___ times a week	☐	☐

	ARE YOU:	Yes	No
51.	Are your feelings easily hurt	☐	☐
52.	Often unhappy or depressed	☐	☐
53.	Taking birth control pills	☐	☐
54.	Currently pregnant	☐	☐
55.	Diagnosed with prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (Botox, Collagen Injections, Etc):

List all medications, supplements, and/or vitamins taken within the last two years.

****Additional medications listed on back of form:* ☐ Yes ☐ No

Drug	Purpose

Drug	Purpose

Preferred pharmacy: _____

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: _____

PATIENT REVIEWED HISTORY AND MEDICATIONS - ACKNOWLEDGED NO CHANGES NEEDED:

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____