MEDICAL HISTORY

Patient Name _____ Preferred Name _____ Age _____

Name of Physician/and their spciality _____

Most recent physical examination _____

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		
	☐ chlorhexicline (CHX)		
	☐ iodine		
	☐ metals (nickel, gold, silver, titanium)		
	☐ latex		
	☐ nuts		
	☐ fruit		
	☐ milk		
	☐ red dye		
	☐ other		
3.	heart problem, or cardiac stent within the last six months	☐	☐
4.	history of infective endocarditis	☐	☐
5.	artificial heart valve, repaired heart defect (PFO)	☐	☐
6.	pacemaker, implantable defribrillator, or organ transplant	☐	☐
7.	orthopedic or soft tissue implant (e.g., joint replacement)	☐	☐
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, insomenia, 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 cholestrol 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.	athritis or gout	☐	☐
28.	autoimmune diease (e.g., rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	glaucoma	☐	☐
30.	contact lenses	☐	☐
31.	head or neck injuries	☐	☐
32.	epilepsy, conulsions (seizures)	☐	☐
33.	neurological 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, immunosuppresive medication	☐	☐
43.	difficulties with stress management	☐	☐
44.	psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45.	concentration problems or ADD/ADHD	☐	☐
46	alcohol/recreational drug use	☐	☐

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 (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 or breastfeeding	☐	☐
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)