

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: <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____ <input type="checkbox"/> penicillin _____ <input type="checkbox"/> erythromycin _____ <input type="checkbox"/> tetracycline _____ <input type="checkbox"/> sulfa _____ <input type="checkbox"/> local anesthetic _____ <input type="checkbox"/> fluoride _____ <input type="checkbox"/> chlorhexidine (CHX) _____ <input type="checkbox"/> iodine _____ <input type="checkbox"/> metals (nickel, gold, silver, _____) <input type="checkbox"/> latex _____ <input type="checkbox"/> nuts _____ <input type="checkbox"/> fruit _____ <input type="checkbox"/> milk _____ <input type="checkbox"/> red dye _____ <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 (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	<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, nasal breathing, 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. difficulties with stress management _____	<input type="checkbox"/>	<input type="checkbox"/>
19. vertigo (e.g., "the room is spinning") _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment, antidepressants, mood stabilizing medications _____	<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"/>	ARE YOU:		
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., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	<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 _____