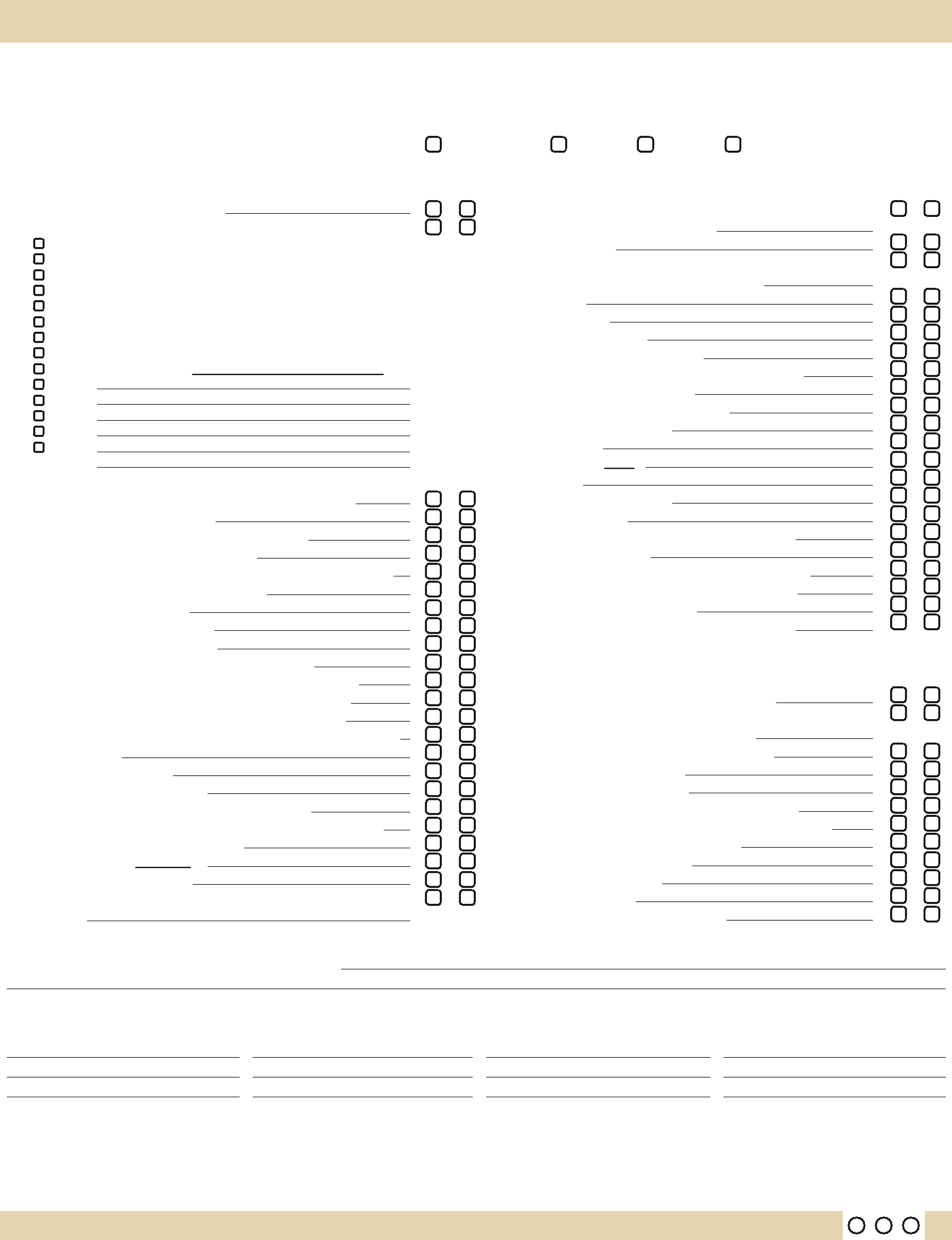
**MEDICAL HISTORY**



|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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

2. an allergic or bad reaction to any of the following: aspirin, ibuprofen, acetaminophen, codeine penicillin

erythromycin

tetracycline

sulfa

local anesthetic

fluoride

chlorhexidine (CHX)

metals (nickel, gold, silver, )

latex

nuts

fruit

milk

red dye

 other

1. heart problems, or cardiac stent within the last six months
2. history of infective endocarditis
3. artificial heart valve, repaired heart defect (PFO)
4. pacemaker or implantable defibrillator
5. orthopedic or soft tissue implant (e.g joint replacement, breast implant)
6. heart murmur, rheumatic or scarlet fever
7. high or low blood pressure
8. a stroke (taking blood thinners)
9. anemia or other blood disorder
10. prolonged bleeding due to a slight cut (or INR > 3.5)
11. pneumonia, emphysema, shortness of breath, sarcoidosis
12. chronic ear infections, tuberculosis, measles, chicken pox
13. breathing problems (e.g. asthma, stuffy nose, sinus congestion)
14. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting)
15. kidney disease
16. liver disease or jaundice
17. vertigo (e.g. ”the room is spinning”)
18. thyroid, parathyroid disease, or calcium deficiency
19. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome)
20. high cholesterol or taking statin drugs

23. diabetes (HbA1c = )

1. stomach or duodenal ulcer
2. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia,

anorexia)

1. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)
2. arthritis or gout
3. autoimmune disease

(e.g. rheumatoid arthritis, lupus, scleroderma)

1. glaucoma
2. contact lenses
3. head or neck injuries
4. epilepsy, convulsions (seizures)
5. neurologic disorders (ADD/ADHD, prion disease)
6. viral infections and cold sores
7. any lumps or swelling in the mouth
8. hives, skin rash, hay fever
9. STI/STD/HPV

38. hepatitis (type )

1. HIV/AIDS
2. tumor, abnormal growth
3. radiation therapy
4. chemotherapy, immunosuppressive medication
5. emotional difficulties
6. psychiatric treatment or antidepressant medication
7. concentration problems or ADD/ADHD diagnosis
8. alcohol/recreational drug use
9. speech difficulties or delayed growth at any time

**AREYOU:**

1. presently being treated for any other illness
2. aware of a change in your health in the last 24 hours

(e.g., fever, chills, new cough, or diarrhea)

1. taking medication for weight management
2. taking dietary supplements
3. often exhausted or fatigued
4. experiencing frequent headaches or chronic pain
5. a smoker, smoked previously or use smokeless tobacco
6. considered a touchy/sensitive person
7. often unhappy or depressed
8. taking birth control pills
9. currently pregnant
10. 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, and or vitamins 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)** | | | |  |  |  |  |  |
|  |  |  |  |  |  |
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