

# Medical History

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date/purpose of last visit \_\_\_\_\_

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

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Please list any other medications taken in the last 2 years not listed above: \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you or have you ever used tobacco?  Yes  No Do you use controlled substances?  Yes  No

Women: Are you  
 Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Acrylic  Latex  Local Anesthetics  Erythromycin  Tetracycline  Fluoride  
 Metals (Gold, Stainless steel)  Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |   |  |                                 |  |   |  |
|---|--|---------------------------------|--|---|--|
| AIDS/HIV Positive                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Digestive Disorders             |  | Leukemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol/Drug Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | (i.e. gastric reflux)           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Swallowing           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia or other blood disorder                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/convulsions (seizures) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral valve prolapse                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any lumps or swelling<br>in the mouth                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive thirst                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis/osteopenia<br>(taking bisphosphonates) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial heart valve                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent headaches              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged bleeding due to a<br>slight cut           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joint  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation treatment                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay fever                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal dialysis                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding disorder                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/failure            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems/disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing or sleeping problems<br>(i.e. snoring, sinus) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet fever                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart pacemaker                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest pains   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis (Type_____)           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid or parathyroid disease                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold sores/Fever blisters                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood pressure             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart disorder                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | High cholesterol                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone medication                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives, rash, hay fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor, abnormal growth                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | HPV(Human Papilioma Virus)      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | Hypoglycemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   |  | Kidney disease                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

Please list any serious illness not listed above, current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. \_\_\_\_\_

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 \_\_\_\_\_