

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health? Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_

HAVE YOU EVER HAD THE FOLLOWING: .. YES NO YES NO

- |  |  |
|--|--|
| <p>1. hospitalization for illness or injury ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>2. <b>ALLERGIC REACTION TO</b> .....</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> aspirin, ibuprofen, acetaminophen .....</li> <li><input type="checkbox"/> penicillin</li> <li><input type="checkbox"/> erythromycin</li> <li><input type="checkbox"/> tetracycline</li> <li><input type="checkbox"/> codeine</li> <li><input type="checkbox"/> local anesthetic</li> <li><input type="checkbox"/> fluoride</li> <li><input type="checkbox"/> metals (gold, stainless steel)</li> <li><input type="checkbox"/> latex</li> <li><input type="checkbox"/> any other medications</li> </ul> <p>3. heart problems ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>4. heart murmur ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>5. rheumatic fever ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>6. scarlet fever..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>7. high blood pressure..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>8. low blood pressure ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>9. a stroke..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>10. artificial prosthesis (i.e. heart valve or joints).. <input type="checkbox"/> NO <input type="checkbox"/></p> <p>11. anemia or other blood disorder ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>12. prolonged bleeding due to a slight cut ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>13. emphysema ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>14. tuberculosis ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>15. asthma ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>16. sinus problems ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>17. kidney disease ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>18. liver disease ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>19. jaundice..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>20. thyroid or parathyroid disease..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>21. hormone deficiency..... <input type="checkbox"/> NO <input type="checkbox"/></p> | <p>22. high cholesterol ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>23. diabetes ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>24. stomach or duodenal ulcer..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>25. digestive disorders/regurgitation ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>26. arthritis..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>27. glaucoma ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>28. contact lenses..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>29. head or neck injuries..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>30. epilepsy, convulsions (seizures) ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>31. viral infections and cold sores ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>32. any lumps or swelling in the mouth..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>33. hives, skin rash, hay fever ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>34. sexually transmitted disease ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>35. hepatitis (type __)..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>36. HIV/ AIDS ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>37. tumor, abnormal growth, cancer..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>38. radiation therapy..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>39. chemotherapy ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>40. psychiatric treatment ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>41. alcohol/drug dependency..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>42. osteoporosis/low bone density..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>DO YOU:</p> <p>43. smoke ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>ARE YOU:</p> <p>44. presently being treated for any illness ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>45. aware of a change in your general health ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>46. often exhausted or fatigued..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>47. subject to frequent headaches ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>48. FEMALE – taking birth control pills..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>49. FEMALE – pregnant ..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>50. MALE – Prostate disorders ..... <input type="checkbox"/> NO <input type="checkbox"/></p> |
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Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment\_\_\_\_

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\_\_\_\_\_

List any medications, herbal supplements, and or vitamins taken within the last two years, or bring a list for us to copy \_\_\_\_\_

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\_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

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