Medical History

Patient Name_____**Nickname**_____**Age**_____
Name of Physician (MD)_____**Physician Phone#**_____
Most recent Physical Exam_____
How would you rate your overall health? Poor_____ **Fair**_____ **Good**_____

Have you ever been:	**Yes**	**No**
Hospitalized for illness or injury?	☐	☐
Allergic reaction to:		
☐ Aspirin		
☐ Penicillin		
☐ Sulfa		
☐ Erythromycin		
☐ Tetracycline		
☐ Codeine		
☐ Local anesthetic		
☐ Fluoride		
☐ Metals		
☐ Latex		
☐ Any other medications_____		

Have you ever had the following:	**Yes**	**No**
Heart problems	☐	☐
Heart murmur	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Scarlet Fever	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Artificial prosthesis (heart valve, joints)	☐	☐
Anemia or other blood disorder	☐	☐
Prolonged bleeding due to slight cut	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Sinus problems	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Jaundice	☐	☐
Thyroid or parathyroid disease	☐	☐
Hormone deficiency	☐	☐
High cholesterol	☐	☐
Diabetes (Type :____)	☐	☐
Dry mouth	☐	☐
Digestive disorders	☐	☐
Stomach or duodenal ulcer	☐	☐

Dr.'s Notes:
_____
_____
_____

	Yes	**No**
Acid Reflux	☐	☐
Arthritis	☐	☐
Glaucoma	☐	☐
Contact lenses	☐	☐
Head or neck injuries	☐	☐
Epilepsy, convulsions (seizures)	☐	☐
Viral infections/cold sores	☐	☐
Lumps or swelling in mouth	☐	☐
Hives, skin rash, hay fever	☐	☐
Venereal disease	☐	☐
Hepatitis (Type :____)	☐	☐
HPV	☐	☐
HIV/AIDS	☐	☐
Tumor, abnormal growth	☐	☐
Cancer (Type :_____)	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Emotional problems	☐	☐
Psychiatric treatment	☐	☐
Antidepressant medication	☐	☐
Alcohol/drug dependency	☐	☐
Sleep Apnea (using a C-PAP machine)	☐	☐

Are you:	**Yes**	**No**
Having joint or valve replacement surgery	☐	☐
Being treated for an illness	☐	☐
Aware of a health change	☐	☐
Often fatigued/ exhausted	☐	☐
Subject to frequent headaches	☐	☐
A Smoker	☐	☐
If yes, how often?_____		
A Tobacco user	☐	☐
If yes, how often?_____		
FEMALE-taking birth control	☐	☐
FEMALE-pregnant	☐	☐
MALE- Prostate Disorders	☐	☐

CURRENT MEDICATIONS AND THE REASON FOR THOSE MEDICINES:
_____
_____
_____
_____
_____

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:_____
_____

*****PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING*****

Patient Signature_____Date_____

Doctor Signature_____ Date_____