MEDICAL HISTORY

Name of Physician(s) _____

Most recent physical examination _____ Purpose _____

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

HAVE YOU EVER HAD THE FOLLOWING: (check all that apply)

1. hospitalization for illness or injury ❑
2. allergic reaction to
   - ❑ aspirin ❑ ibuprofen ❑ acetaminophen
   - ❑ penicillin
   - ❑ erythomycin
   - ❑ tetracycline
   - ❑ codeine
   - ❑ local anesthetic
   - ❑ flouride
   - ❑ metals (gold, stainless steel)
   - ❑ latex
   - ❑ any other medications _____
3. heart problems ❑
4. high blood pressure ❑
5. low blood pressure ❑
6. a stroke ❑
7. artificial prosthesis (i.e. heart valve or joints) ❑
8. anemia or other blood disorder ❑
9. prolonged bleeding due to a slight cut ❑
10. emphysema ❑
11. tuberculosis ❑
12. asthma ❑
13. breathing or sleep problems (i.e. snoring, sinus) ❑
14. thyroid or parathyroid disease ❑
15. hormone deficiency ❑
16. high cholesterol ❑
17. diabetes ❑
18. digestive disorders (i.e. gastric reflux) ❑
19. arthritis ❑
20. glaucoma ❑
21. head or neck injuries ❑
22. epilepsy, convulsions (seizures) ❑
23. neurologic problems ❑
24. viral infections and cold sores ❑
25. any lumps or swelling in the mouth ❑
26. hives, skin rash, hay fever ❑
27. hepatitis (type _____) ❑
28. HIV/AIDS ❑
29. tumor, abnormal growth ❑
30. radiation therapy ❑
31. chemotherapy ❑
32. recent surgery ❑
33. sinus problems ❑
34. tonsils or adnoids removed ❑

ARE YOU:

35. presently being treated for any other illness ❑
36. aware of a change in your general health ❑
37. taking medication for osteoporosis/osteopenia ❑
38. often exhausted or fatigued ❑
39. subject to frequent headaches ❑
40. a smoker or smoked previously ❑
41. FEMALE – taking birth control ❑
42. FEMALE – pregnant ❑

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List any medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

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 _____