MEDICAL HISTORY

Patient Name_____Nickname_____Birthdate_____

Name of Physician, Address, phone #_____

Date of last physical exam_____Purpose_____
What is your estimate of your general health? Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING:

1. hospitalization for illness or injury Y / N
2. allergic reaction to
   - ❒aspirin, ibuprofen, acetominophen
   - ❒penicillin
   - ❒erythromycin
   - ❒tetracycline
   - ❒codeine
   - ❒local anaesthetic
   - ❒fluoride
   - ❒metals (gold, stainless steel)
   - ❒latex
   - ❒any other_____
3. heart problems_____Y / N
4. heart murmur_____Y / N
5. rheumatic fever_____Y / N
6. scarlet fever_____Y / N
7. high blood pressure_____Y / N
8. low blood pressure_____Y / N
9. stroke_____Y / N
10. artificial prosthesis (heart valve or joint)_____Y / N
11. anemia or other blood disorder_____Y / N
12. prolonged bleeding due to a slight cut_____Y / N
13. emphysema_____Y / N
14. tuberculosis_____Y / N
15. asthma_____Y / N
16. sinus problems_____Y / N
17. kidney disease_____Y / N
18. liver disease_____Y / N
19. jaundice_____Y / N
20. thyroid or parathyroid disease_____Y / N
21. hormone deficiency_____Y / N
22. high cholesterol_____Y / N
23. diabetes_____Y / N
24. stomach or duodenal ulcer_____Y / N
25. digestive disorders_____Y / N
26. arthritis_____Y / N
27. glaucoma_____Y / N
28. contact lenses_____Y / N
29. head or neck injuries_____Y / N
30. epilepsy, convulsions, seizures_____Y / N
31. viral infections and cold sores_____Y / N
32. any lumps or swellings in the mouth_____Y / N
33. hives, skin, rash, hay fever_____Y / N
34. venereal disease_____Y / N
35. hepatitis (type___)_____Y / N
36. HIV / AIDS_____Y / N
37. tumor, abnormal growth, cancer_____Y / N
38. radiation therapy_____Y / N
39. chemotherapy_____Y / N
40. emotional problems_____Y / N
41. psychiatric treatment_____Y / N
42. antidepressant medication_____Y / N
43. alcohol / drug dependency_____Y / N

ARE YOU:

44. presently being treated for any illness_____Y / N
45. aware of a change in you r general health__Y / N
46. often exhausted or fatigued_____Y / N
47. subject to frequent headaches_____Y / N
48. a smoker (__packs/day)_____Y / N
49. considered a touchy person_____Y / N
50. often unhappy or depressed_____Y / N
51. easily upset or irritated_____Y / N
52. FEMALE – taking birth control pills_____Y / N
53. FEMALE – pregnant_____Y / N
54. MALE – have prostate disorders_____Y / N

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

_____

List any medications taken within the last two years_____

_____

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

Patient Signature_____Date_____

Doctor's Remarks_____Doctor's Signature_____

OVER