

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Date of last physical examination _____ Purpose _____

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

Do you have any of the following:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. been hospitalized for illness or injury | <input type="checkbox"/> | <input type="checkbox"/> | 26. arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. allergic reaction to | | | 27. glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin | | | 28. contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. head or neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. epilepsy, convulsions (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> codeine | | | 31. viral infections and cold sores | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 32. any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 33. hives, skin rash, hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (gold, stainless steel) | | | 34. venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> any other medications _____ | | | 35. hepatitis (type _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems | <input type="checkbox"/> | <input type="checkbox"/> | 36. HIV / AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | 37. tumor, abnormal growth | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | 38. radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | 39. chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 40. emotional problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 41. psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a stroke | <input type="checkbox"/> | <input type="checkbox"/> | 42. antidepressant medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. artificial prosthesis (i.e. heart valve or joints) | <input type="checkbox"/> | <input type="checkbox"/> | 43. alcohol / drug dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. emphysema | <input type="checkbox"/> | <input type="checkbox"/> | 44. presently being treated for any illness | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | 45. aware of a change in your general health | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma | <input type="checkbox"/> | <input type="checkbox"/> | 46. often exhausted or fatigued | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | 47. subject to frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | 48. a heavy smoker (1 pack or more a day) | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease | <input type="checkbox"/> | <input type="checkbox"/> | 49. considered a touchy person | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 50. often unhappy or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid or parathyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | 51. easily upset or irritated | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 52. FEMALE - taking birth control pills | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | 53. FEMALE - pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 54. MALE - Prostate disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | 55. have you taken prescription diet drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders | <input type="checkbox"/> | <input type="checkbox"/> | 56. implants, rods, plates, pins, screws | <input type="checkbox"/> | <input type="checkbox"/> |

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's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____