

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

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

DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

YES NO

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic or bad reaction to any of the following: | <input type="checkbox"/> | <input type="checkbox"/> | 27. arthritis or gout _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____ | | | 28. autoimmune disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin _____ | | | (e.g. rheumatoid arthritis, lupus, scleroderma) _____ | | |
| <input type="checkbox"/> erythromycin _____ | | | 29. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline _____ | | | 30. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa _____ | | | 31. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic _____ | | | 32. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride _____ | | | 33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> chlorhexidine (CHX) _____ | | | 34. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> iodine _____ | | | 35. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 36. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex _____ | | | 37. STI/STD/HPV _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> nuts _____ | | | 38. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fruit _____ | | | 39. HIV/AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> milk _____ | | | 40. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> red dye _____ | | | 41. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 42. chemotherapy, immunosuppressive medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. emotional difficulties _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. psychiatric treatment or antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. concentration problems or ADD/ADHD _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. alcohol/recreational drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 8. heart murmur, rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 10. a stroke (taking blood thinners) _____ | <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 (or INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. pneumonia, emphysema, shortness of breath, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. chronic ear infections, tuberculosis, measles, chicken pox _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. liver disease or jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 19. vertigo (e.g. "the room is spinning") _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

ARE YOU:

- | | | |
|---|--------------------------|--------------------------|
| 47. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. aware of a change in your health in the last 24 hours _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| (e.g., fever, chills, new cough, or diarrhea) _____ | | |
| 49. taking medication for weight management _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. taking dietary supplements, vitamins, and/or probiotics _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. experiencing frequent headaches or chronic pain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. considered a touchy/sensitive person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. currently pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. diagnosed with a prostate disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 _____