

# Medical History

Name of Previous Dentist \_\_\_\_\_

Name of Physician \_\_\_\_\_

Most recent physical exam \_\_\_\_\_ Purpose \_\_\_\_\_

Have you been hospitalized for illness or injury? \_\_\_\_\_

**DO YOU HAVE ANY ALLERGIES TO:**

- Penicillin
- Asprin, Ibuprofen, Aceteminophen
- Erythromycin
- Tetracycline
- Codeine
- Local Anesthetic
- Metals (gold, stainless steel)
- Latex
- Other \_\_\_\_\_

- Osteoperosis/Osteopenia
- Arthritis/Osteoarthritis/Rheumatoid
- Glaucoma
- Head or neck injuries; Date: \_\_\_\_\_
- Hives, skin rash, hay fever
- Epilepsy, Seizures
- Neurologic problems
- Viral infections/cold sores
- HIV positive
- Venereal disease
- Hepatitis (Type A, Type B, Type C )
- Tumor, abnormal growth
- Radiation therapy; Date: \_\_\_\_\_
- Chemotherapy; Date: \_\_\_\_\_
- Emotional issues
- Psychiatric treatment
- Alcohol/drug dependency or Social drinker
- Parkinsons
- Alzheimers
- Dementia

**DO YOU HAVE OR HAVE YOU EVER HAD:**

- Heart problem \_\_\_\_\_
- Heart murmer
- Rheumatic fever
- Scarlet fever
- High Blood Pressure
- Low Blood Pressure
- A Stroke; Date: \_\_\_\_\_
- Artificial prosthesis (heart valve or joint) \_\_\_\_\_
- Anemia or other Blood disorder
- Prolonged bleeding due to a slight cut
- Emphysema
- Asthma
- Breathing/Sleep problems (Apnea)
- Kidney disease
- Liver disease
- Jaundice
- Thyroid or Parathyroid disease
- Hormone deficiency
- High cholesterol
- Diabetes ( Type 1, Type 2 )
- Stomach or duodenal ulcer
- Digestive disorder (reflux, colitis, GERD)

**ARE YOU:**

- Taking Bisphosphonates
- A smoker or previous smoker
- Suffering from depression
- Taking Antidepressant medication
- Often exhausted/tired
- Taking dietary supplements
- Taking weight management meds
- Aware of a general change of health
- Subject to frequent headaches
- FEMALE ONLY: Taking Birth Control
- FEMALE ONLY: Pregnant
- MALE ONLY: Prostate disorder

Describe any current medical treatment, impending surgery or other treatment that may affect your dental treatment \_\_\_\_\_

**List of all medication, supplement and or vitamins you are currently taking**

<u>Drug</u>	<u>Purpose</u>	<u>Drug</u>	<u>Purpose</u>

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDIAL HISTORY OR ANY MEDICATION YOU MAY BE TAKING**

**Patients Signature** \_\_\_\_\_ **Date** \_\_\_\_\_