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## Medical History

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

**Title:** _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

**Birth Date:** _____ **Prev. Visit:** _____ **Email Address:** _____

**Phone:** _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

**Address:** _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

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

**DO YOU HAVE or HAVE YOU EVER HAD:**

**1. Hospitalization for illness or injury** ◯ Yes ◯ No

**2. An allergic or bad reaction to any of the following:** ◯ Yes ◯ No

- ☐ aspirin, ibuprofen, acetaminophen, codeine
- ☐ penicillin
- ☐ erythromycin
- ☐ tetracycline
- ☐ sulfa
- ☐ local anesthetic
- ☐ fluoride
- ☐ iodine
- ☐ chlorhexidine (CHX)
- ☐ metals (nickel, gold, silver_____)
- ☐ latex
- ☐ nuts
- ☐ fruit
- ☐ shellfish
- ☐ seasonal
- ☐ other

**3. Heart problems, angina or cardiac stent within the last six months** ◯ Yes ◯ No

**4. History of infective endocarditis** ◯ Yes ◯ No

**5. Diagnosed with congestive heart failure?** ◯ Yes ◯ No

**6. Artificial heart valve, repaired heart defect (PFO)** ◯ Yes ◯ No

**7. Pacemaker or implantable defribrillator** ◯ Yes ◯ No

**8. Orthopedic implant (joint replacement)** ◯ Yes ◯ No

**9. Rheumatic or scarlet fever** ◯ Yes ◯ No

**10. High or low blood pressure** ◯ Yes ◯ No

**11. A stroke?** ◯ Yes ◯ No

**If answered yes above, please list date(s):**

_____

_____

**12. A heart attack?** ◯ Yes ◯ No

**If answered yes above, please list date(s):**

_____

_____

**13. Anemia or other blood disorder** ◯ Yes ◯ No

**14. Prolonged bleeding due to a slight cut (INR > 3.5)** ◯ Yes ◯ No

**15. Are you taking blood thinners (i.e. coumadin)** ◯ Yes ◯ No

**16. Pneumonia, emphysema, shortness of breath, sarcoidosis** ◯ Yes ◯ No

**17. Chronic ear infections, tuberculosis, measles, chicken pox** ◯ Yes ◯ No

**18. Asthma** ◯ Yes ◯ No

**19. Breathing or sleep problems (e.g., sleep apnea, snoring, sinus)** ◯ Yes ◯ No

**20. Do you wear a CPAP or appliance?** ◯ Yes ◯ No

**21. Kidney disease** ◯ Yes ◯ No

**22. Liver disease** ◯ Yes ◯ No

**23. Jaundice** ◯ Yes ◯ No

**24. Thyroid, parathyroid disease, or calcium deficiency** ◯ Yes ◯ No

**25. Hormone deficiency** ◯ Yes ◯ No

**26. High cholesterol or taking statin drugs** ◯ Yes ◯ No

**27. Diabetes?** ◯ Yes ◯ No

**If answered yes, please note HbA1c:** _____

**28. Stomach or duodenal ulcer** ◯ Yes ◯ No

**29. Digestive or eating disorders (e.g., celiac disease, gastric reflux, GERD, bulimia, anorexia)** ◯ Yes ◯ No

**30. Osteoporosis/osteopenia (e.g., taking bisphosphonates)** ◯ Yes ◯ No

**31. Do you take bisphosphonates (i.e fosomax)?** ◯ Yes ◯ No

**32. Arthritis** ◯ Yes ◯ No

**33. Autoimmune disease (e.g., rheumatoid arthritis, lupus, schleroderma)** ◯ Yes ◯ No

**34. Glaucoma** ◯ Yes ◯ No

**35. Contact lenses** ◯ Yes ◯ No

**36. Head or neck injuries** ◯ Yes ◯ No

**37. Epilepsy, convulsions (seizures)** ◯ Yes ◯ No

**38. Neurologic disorders (ADD/ADHD, prion disease)** ◯ Yes ◯ No

**39. Viral infections, cold sores** ◯ Yes ◯ No

**40. Any lumps or swelling in the mouth** ◯ Yes ◯ No

**41. Hives, skin rash, hay fever** ◯ Yes ◯ No

**42. STI/STD/HPV** ◯ Yes ◯ No

**43. Hepatitis?** ◯ Yes ◯ No

**If answered yes, please note Hepatitis type:** _____

**44. HIV/AIDS** ◯ Yes ◯ No

**45. Tumor, cancer?** ◯ Yes ◯ No

**If answered yes, please note date(s) of diagnosis and type(s):**

_____

_____

**46. Radiation theraphy** ◯ Yes ◯ No

**47. Chemotherapy, immunosuppressive medication** ◯ Yes ◯ No

**48. Emotional difficulties** ◯ Yes ◯ No

**49. Dizziness/fainting** ◯ Yes ◯ No

**50. Psychiatric treatment** ◯ Yes ◯ No

**51. Antidepressant medication** ◯ Yes ◯ No

**52. Alcohol/recreational drug use** ◯ Yes ◯ No

ARE YOU:

**53. Presently being treated for any other illness** ◯ Yes ◯ No

**54. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)** ◯ Yes ◯ No

**55. Taking medication for weight management** ◯ Yes ◯ No

**56. Taking dietary supplements** ◯ Yes ◯ No

**57. Often exhausted or fatigued** ◯ Yes ◯ No

**58. Experiencing frequent headaches** ◯ Yes ◯ No

**59. A smoker, smoked previously or use smokeless tobacco** ◯ Yes ◯ No

**50. Considered a touch/sensitive person** ◯ Yes ◯ No

**61. Often unhappy or depressed** ◯ Yes ◯ No

**62. Taking birth control pills** ◯ Yes ◯ No

**63. Currently pregnant** ◯ Yes ◯ No

**64. Diagnosed with a prostate disorder** ◯ Yes ◯ No

**If any conditions or alerts selected above need further clarification, please describe below:**

**Do you take antibiotic premedication for your dental visits? If yes, please explain.**

**Name of your physician and phone number:**

**Name, location, and phone number of your preferred pharmacy:**

**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 (prescription and non-prescription) including regular doses of aspirin:**

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

**Response Date: ___/___/_____**