MEDICAL HISTORY

Patient Name: ________________ Nickname: ________________ Age: ______

Name of Physician/and their specialty: ________________ Phone #: ________________

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

1. Hospitalization for illness or injury ________ ☐ ☐
2. An allergic reaction to: **(Circle)** ________ ☐ ☐
   Aspirin, Ibuprofen, Acetaminophen, Codeine, Penicillin, Erythromycin, Tetracycline, Sulpha, Local anesthetic, Flouride, Metals (nickel, gold, silver), Clindamycin, Valuim or other sedatives, Latex
3. Are you taking any of these Medications? **(Circle)** ________ ☐ ☐
   Tagamet® (cimetidine), Prilosec® (omeprazole), Cardizem® (diltiazem), Calan, Isoptin® (Verapamil), Pre-medication before dental treatment, Serzone® (nefazodone), Dilantin®, Tegretol, Barbiturates (any), Biaxin® (clarithromycin), St. John's Wort, Kava-Kava

P 4. Heart problems or cardiac stent within the last six months ☐ ☐

5. History of infective endocarditis ________ ☐ ☐

6. Artificial heart valve, repaired heart defect ________ ☐ ☐

P 7. Pacemaker, implantable defibrillator ________ ☐ ☐

8. Artificial replacement joints (Year?)__ ________ ☐ ☐

9. Rheumatic or scarlet fever ________ ☐ ☐

P 10. High or Low blood pressure (circle) Your normal BP=____ ☐ ☐

11. A stroke ________ ☐ ☐

12. Anemia or other blood disorder ________ ☐ ☐

13. Prolonged bleeding due to slight cut (INR>3.5) ________ ☐ ☐

14. Emphysema, sarcoidosis ________ ☐ ☐

15. Tuberculosis ________ ☐ ☐

16. Asthma ________ ☐ ☐

17. Breathing, Sleeping problems, Snoring, Sinus (circle)____ ☐ ☐

18. Kidney disease ________ ☐ ☐

19. Liver disease ________ ☐ ☐

20. Jaundice ________ ☐ ☐

21. Thyroid, Parathyroid disease (circle) ________ ☐ ☐

22. Hormone deficiency ________ ☐ ☐

23. High cholesterol, taking statin drugs (circle) ________ ☐ ☐

P 24. Diabetes (HbA1c) ________ ☐ ☐

B 25. Stomach, duodenal ulcer (circle)________ ☐ ☐

B 26. Digestive disorders, Gastric/acid reflux ________ ☐ ☐

27. Osteoporosis/Osteopenia ☐ ☐

28. Have you been treated w/ Bisphosphonate drug's? (circle) ☐ ☐
(Fosamax®, Aredia®, Zometa®, Actonel®, Boniva, RANKL, Denosumab, Prolia)

P 29. Arthritis ________ ☐ ☐

30. Glaucoma________ ☐ ☐

31. Contact lenses ________ ☐ ☐

32. Head or neck injuries ________ ☐ ☐

33. Epilepsy, convulsions (seizures) ________ ☐ ☐

34. Neurologic problems (attention deficit disorder)________ ☐ ☐

35. Viral infections and cold sores ________ ☐ ☐

36. Any lumps or swelling in the mouth ________ ☐ ☐

37. Hives, skin rash, hay fever(circle) ________ ☐ ☐

38. Venereal disease ________ ☐ ☐

39. Hepatitis (type ____) ________ ☐ ☐

40. HIV / AIDS ________ ☐ ☐

41. Tumor, abnormal growth ________ ☐ ☐

B 42. Radiation therapy ________ ☐ ☐

B 43. Chemotherapy ________ ☐ ☐

P 44. Emotional problems ________ ☐ ☐

45. Psychiatric treatment ________ ☐ ☐

B 46. Antidepressant medication ________ ☐ ☐

BP 47. Alcohol, Drug dependency (circle) ________ ☐ ☐

48. Please provide current weight: ________

ARE YOU:

49. Presently being treated for any other illness ________ ☐ ☐

50. Aware of a change in your general health ________ ☐ ☐

51. Taking medication for weight management (fen-phen) ☐ ☐

52. Taking dietary supplement ________ ☐ ☐

53. Often exhausted or fatigued ________ ☐ ☐

54. Subject to frequent headaches ________ ☐ ☐

P 55. A smoker or smoked previously (circle) ________ ☐ ☐

56. Considered a touchy person ________ ☐ ☐

57. Often unhappy or depressed ________ ☐ ☐

58. Consume grapefruit juice, grapefruits or grapefruit extract? ☐ ☐

59. MALE – prostate disorders: ________ ☐ ☐

60. FEMALE – Taking Birth Control pills ________ ☐ ☐

61. FEMALE – Pregnant ________ ☐ ☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

____

List all medications, supplements, and or vitamins taken in the last two years

Drug	Dosage	Purpose	Drug	Dosage	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:** ________________

3/4/2011