Medical History

Name of Physician_____

Most recent physical examination_____Purpose_____

What is you estimate of your general health? Poor_____ Fair_____ Good_____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. Hospitalization for illness or injury	☐	☐
2. Allergic reaction to...		☐
☐ Aspirin, Ibuprofen, acetomenophen		
☐ Penicillin		
☐ Tetracycline		
☐ Codeine		
☐ Local Anesthetic		
☐ Fluoride		
☐ Metals (Gold, stainless steel)		
☐ Latex		
☐ Any other medications_____		
3. Heart problems	☐	☐
4. Heart murmur	☐	☐
5. Rheumatic fever	☐	☐
6. Scarlet fever	☐	☐
7. High blood pressure	☐	☐
8. Low blood pressure	☐	☐
9. A stroke	☐	☐
10. Artificial Prosthesis (i.e. heart valve or joints)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut	☐	☐
13. Emphysema	☐	☐
14. Tuberculosis	☐	☐
15. Asthma	☐	☐
16. Sinus problems	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid or parathyroid disease	☐	☐
21. Hormone Deficiency	☐	☐
22. High cholesterol	☐	☐
23. Diabetes	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive disorder	☐	☐

	YES	NO
26. Arthritis	☐	☐
27. Glaucoma	☐	☐
28. Contact Lenses	☐	☐
29. Head or neck injuries	☐	☐
30. Epilepsy, convulsions (seizures)	☐	☐
31. Viral infections and cold sores	☐	☐
32. Any lumps or swelling in the mouth	☐	☐
33. Hives, skin rash, hay fever	☐	☐
34. Venereal disease	☐	☐
35. Hepatitis (type___)	☐	☐
36. HIV/AIDS	☐	☐
37. Tumor, abnormal growth	☐	☐
38. Radiation therapy	☐	☐
39. Chemotherapy	☐	☐
40. Emotional problems	☐	☐
41. Psychiatric treatment	☐	☐
42. Antidepressant medication	☐	☐
43. Alcohol/drug dependancy	☐	☐
ARE YOU:		
44. Presently being treated for any illness	☐	☐
45. Aware of any change in your general health	☐	☐
46. Often exhausted or fatigued	☐	☐
47. Subject to frequent headaches	☐	☐
	☐	☐
	☐	☐
	☐	☐
51. Easily upset or irritated	☐	☐
52. FEMALE- Taking birthcontrol pills	☐	☐
53. FEMALE- Pregnant	☐	☐
	☐	☐

Please desribe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

_____

List any medications, herbal supplements, and or vitamins 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:_____

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