MEDICAL HISTORY

For office use only: Blood Pressure: _____ Pulse: _____

Patient Name: _____ DOB: _____ Today's Date: _____

Primary Physician: _____ Date of Last Physical Exam: _____

Preferred Pharmacy: _____

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

DO YOU OR HAVE YOU EVER HAD:	**Yes**	**No**
1. Hospitalization for illness or injury	☐	☐
2. An allergic or bad reaction to any of the following:	☐	☐

- ☐ Pain medications: _____
- ☐ Local anesthetics: _____
- ☐ Sedatives: _____
- ☐ Metals: _____
- ☐ Fluoride
- ☐ Latex
- ☐ Others: _____

3. Heart problems or cardiac stents within the last 6 months	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve, repaired heart defect	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Orthopedic implant (joint replacement)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. Stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. Pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. Tuberculosis, measles, chicken pox	☐	☐
15. Asthma	☐	☐
16. Breathing or sleeping problems (snoring, sleep apnea, sinus)	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid, parathyroid disease or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking statin drugs	☐	☐
23. Diabetes (Type: _____ HbA1c = _____)	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive or eating disorders	☐	☐
26. Thyroid disorders	☐	☐
27. Osteoporosis/osteopenia (taking bisphosphonate)	☐	☐
28. Arthritis	☐	☐
29. Autoimmune disease (rheumatoid, lupus, scleroderma)	☐	☐
30. Glaucoma	☐	☐
31. Contact lenses	☐	☐
32. Head or neck injuries	☐	☐
33. Epilepsy, convulsions (seizures)	☐	☐
34. Neurologic disorders (ADD/ADHD, prion disease)	☐	☐

35. Viral infections or cold sores…… ☐ ☐
36. Any lumps or swelling in the mouth…… ☐ ☐
37. Hives, skin rash, hay fever…… ☐ ☐
38. STD/HPV…….. ☐ ☐
39. Hepatitis (Type: _____)..... ☐ ☐
40. HIV/AIDS…….. ☐ ☐
41. Tumor, abnormal growth…….... ☐ ☐
42. Radiation therapy…… ☐ ☐
43. Chemotherapy, immunosuppressive medications…… ☐ ☐
44. Emotional difficulties…….. ☐ ☐
45. Psychiatric treatment…….. ☐ ☐
46. Antidepressant medications…….. ☐ ☐
47. Alcohol/recreational drug use…… ☐ ☐

ARE YOU:	**Yes**	**No**
48. Presently being treated for any other illnesses……..	☐	☐
49. Aware of a change in your health in the last 24 hours……..	☐	☐
50. Taking medication for weight management……	☐	☐
51. Taking dietary supplements……..	☐	☐
52. Often exhausted or fatigued……..	☐	☐
53. Experiencing frequent headaches……	☐	☐
54. A smoker or previous smoker……...	☐	☐
55. Often unhappy or depressed……	☐	☐
56. Taking birth control pills……..	☐	☐
57. Currently pregnant……..	☐	☐
58. Diagnosed with a prostate disorder……..	☐	☐

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

_____

_____

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

_____

_____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the denturist/dentist/hygienist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payouts and/or health practitioners.

Patient/Parent/Guardian Signature:

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