MEDICAL HISTORY

Patient Name: _____ DOB: ____/____/_____
Last First Middle

Gender __ M __ F __rather not answer Race: _____

Height: _____ Weight:_____ Glucose: _____ A1c (if diabetic): _____

Are you currently under physician care? ____ Reason: _____ Date of last visit:_____

Primary physician: _____ Phone: _____

Have there been any changes to your general health in the last 5 years?_____

Have you had any illness, operation or been hospitalized in the past 5 years? _____

Reason: _____

Are you allergic to any of the following: local anesthetic, Penicillin/antibiotics, Barbiturates, Sulfa drugs, Latex, Codeine or other narcotics, nickel? _____Type of reaction_____

Other Allergies: _____

Yes	No	D/K	
			Has your physician recommended that you take antibiotics prior to dental treatment?
			Have you had an orthopedic total joint replacement? When? _____
			Do you have a heart murmur or a history of rheumatic heart disease?
			Have you taken biphosponates? How long?
			Have you taken cortisone (steroids) in the last 30 days?
			Do you use or have you used recreational (street) drugs? _____
			Have you received treatment for chemical or alcohol dependency? _____
			Have you used tobacco? Amount: _____ # years_____ Stopped?_____

Medications: Please fill the chart on the last page with all the medications that you take, the dosage and the reason for taking them.

Surgeries: Please list any previous Surgery with its date and further treatment if applies, on the chart on the last page.

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SYSTEMS REVIEW – check all that apply

Cardiovascular Conditions
- ☐ Angina
- ☐ Atherosclerosis
- ☐ Artificial heart valve
- ☐ Internal defibrillator
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congenital heart disease
- ☐ Mitral valve prolapse
- ☐ Bypass surgery
- ☐ Pacemaker

Respiratory Conditions
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ Sinusitis
- ☐ COPD

Gastrointestinal Conditions
- ☐ Colon Disorders
- ☐ Persistent diarrhea
- ☐ Difficulty swallowing
- ☐ Gastroesophageal reflux
- ☐ Ulcers
- ☐ Malnutrition
- ☐ Jaundice
- ☐ Gallbladder trouble/stones
- ☐ Liver disease
  - ☐ Hepatitis A B C
  - ☐ Cirrhosis
  - ☐ Other

Endocrine Conditions
- ☐ Thyroid problems _____
- ☐ Parathyroid conditions _____
- ☐ Diabetes Type_____
- ☐ Hypoglycemia

Genitourinary Conditions
- ☐ Kidney problems
- ☐ Frequent urinary infections
- ☐ Bladder infection
- ☐ Dialysis

Infectious disease
- ☐ Type _____

Cancer
- ☐ Site: _____
- ☐ Surgery date: _____
- ☐ Chemo _____
- ☐ Radio _____

Bone & Joint Conditions
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Trauma/frequent fractures
- ☐ TMJ problems
- ☐ Jaw Surgery

Bleeding abnormalities
- ☐ Prolonged bleeding
- ☐ Anemia
- ☐ Sickle cell disease_ trait_____
- ☐ Hemophilia type _____
- ☐ Blood transfusion year _____

Neurologic Conditions
- ☐ Epilepsy
- ☐ Convulsions/ seizures
- ☐ Stroke
- ☐ Neuritis
- ☐ Neuralgia/tics
- ☐ Numbness/Paralysis
- ☐ Severe frequent headaches
- ☐ Migraines
- ☐ Repeated blackouts/ fainting
- ☐ Chronic facial pain

Psychologic Treatment
- ☐ Depression
- ☐ Anxiety or panic disorders
- ☐ Eating disorders
- ☐ Other _____

Dermatologic Conditions
- ☐ Chronic/recurrent skin rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other_____

Immune Conditions
- ☐ AIDS or HIV infection
- ☐ Rheumatoid arthritis
- ☐ Immunosupression
  - ☐ Disease-induced _____
  - ☐ Drug-induced _____
  - ☐ Radiation induced _____

Other_____

Other
- ☐ Domestic violence victim
- ☐ Glaucoma
- ☐ Organ/Tissue transplant
- ☐ Night sweats
- ☐ Unintended weight loss
- ☐ Chronic pain site
- ☐ Other that has not been discussed: _____
  _____
  _____

Additional Information on medical conditions_____

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MEDICATIONS (Include prescribed, Over-the-counter and Herbal or Natural)			
Drug	Dose/Day	Date Started	Reason

SURGERIES (Include all the surgeries that you have undergone)		
Surgery	Date	Comments

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature: _____ Date: _____

If other than the patient, indicate relationship: parent or legal guardian _____