MEDICAL HISTORY

Patient Name : _____Age : _____
Name of Physician : _____
Most recent physical examination : _____ Purpose :_____
What is your estimate of your general health: Poor: ___ Fair : ___ Good : ____ Excellent : ____

HAVE YOU EVER HAD THE FOLLOWING?

YES NO

YES NO

1. Have you had an allergic reaction to : * *
* aspirin, ibuprofen, acetaminophen
* penicillin
* erythromycin
* tetracycline
* codeine
* local anesthetic
* fluoride
* metals (gold, stainless steel)
* latex
* any other medications _____

YES NO

2. Hospitalization for illness or injury …… * *
3. Heart problems …… * *
4. Heart murmur ……..* *
5. Rheumatic fever …….. * *
6. Scarlet fever …… * *
7. High blood pressure …….. * *
8. Low blood pressure …… * *
9. Stroke …….. * *
10. Artificial prosthesis (ie. Heart valve or joints) … * *
11. Anemia or other blood disorder …….. * *
12. Prolonged bleeding due to 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 disorders …….. * *

25. Digestive disorders …….. * *

PLEASE ADVISE US IN THE FUTURE ANY TIME THE MEDICAL HISTORY OR MEDICATIONS CHANGE

Please describe any current medical treatment, impending surgery or other treatment that may possibly effect your dental treatment: _____ _____

Patient's Signature _____

Dr.'s Remarks : _____

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 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 dependency …….. * *

ARE YOU?

44. Presently being treated for any illness …… * *
45. Aware of a change in your general health …… * *
46. Often exhausted or fatigued ……... * *
47. Subject to frequent headaches …….. * *
48. A heavy smoker (1 or more packs a day) …… * *
49. Uncomfortable with physical contact …… * *
50. Often unhappy or depressed …….. * *
51. Easily upset or irritated …….. * *
52. FEMALES –taking birth control pills …… * *
53. FEMALES- pregnant …… * *
54. MALES –prostate disorders …… * *

List any medications: (also herbal or vitamins in last 2 yrs)
_____
_____

Date: _____

Dr.’s Signature: _____