

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:		YES	NO	YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	26. arthritis	<input type="checkbox"/>	<input type="checkbox"/>
2. allergic reaction to			27. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetomenophen			28. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			32. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			35. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			37. tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems	<input type="checkbox"/>	<input type="checkbox"/>	38. radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	39. chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	40. emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	41. psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	42. antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	43. alcohol / drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke	<input type="checkbox"/>	<input type="checkbox"/>			
10. artificial prosthesis (i.e. heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	44. presently being treated for any illness	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut	<input type="checkbox"/>	<input type="checkbox"/>	45. aware of a change in your general health	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema	<input type="checkbox"/>	<input type="checkbox"/>	46. often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	47. subject to frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma	<input type="checkbox"/>	<input type="checkbox"/>	48. a heavy smoker (1 pack or more a day)	<input type="checkbox"/>	<input type="checkbox"/>
16. sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	49. considered a touchy person	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	50. often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	51. easily upset or irritated	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	52. FEMALE - taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	53. FEMALE - pregnant	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	54. MALE - Prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			
23. diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
24. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>			

Please describe 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: _____

Doctor's Signature _____