

Medical History

Patient: _____



1. Are you currently under the care of a medical doctor? Yes No
If yes, for what condition/s are you being treated? _____

3. When was your last medical check-up? _____

2. Do you have a family doctor? Name: _____
Phone Number: _____

4. Have you experienced excessive weight gain or loss recently? Yes No

5. Women: Are you currently pregnant or breast feeding? Yes No

6. Have you been hospitalized previously? Reason _____

7. Have you ever been diagnosed or treated for any of the following conditions?

Heart problems

- | | Yes | No |
|------------------------------------|--------------------------|--------------------------|
| 1. Heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Angina Pectoralis or chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Congenital heart defect | <input type="checkbox"/> | <input type="checkbox"/> |

Blood Disorders

- | | | |
|------------------------|--------------------------|--------------------------|
| 13. Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Prolonged bleeding | <input type="checkbox"/> | <input type="checkbox"/> |

Breathing and Lungs

- | | | |
|---|--------------------------|--------------------------|
| 17. Hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |

Digestive Problems

- | | | |
|------------------------|--------------------------|--------------------------|
| 23. Chrones disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Ulcerative colitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Celiac disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 26. G.E.R.D. (Gastro-esophageal reflux disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Stomach or duodenal ulcers | <input type="checkbox"/> | <input type="checkbox"/> |

Metabolic Disorders

- | | | |
|------------------------|--------------------------|--------------------------|
| 30. High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Hyperthyroidism | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Addison's disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Cushing's disease | <input type="checkbox"/> | <input type="checkbox"/> |

Viral ailments

- | | | |
|---------------------|--------------------------|--------------------------|
| 37. Hepatitis A B C | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Cold sores | <input type="checkbox"/> | <input type="checkbox"/> |

Other Conditions

- | | | |
|--------------------------------------|--------------------------|--------------------------|
| 40. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Malignant hyperthermia | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Bulimia/Anorexia | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Substance abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Do you smoke | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Do you have a hearing impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Psychiatric ailment | <input type="checkbox"/> | <input type="checkbox"/> |

8. Have you ever experienced a reaction to, or are aware of an existing allergy to any of the following?

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Metals (gold, silver, nickel) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Local anesthetics or general anesthetics | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Aspirin, acetaminophen, ibuprophen | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Tetracycline | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fluoride | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Sulfa based medications | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Known allergy to other medications: (please list) | | |

9. Are you currently taking any of the following medications?

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Bisphosphonates (Fosamax, Didrocal, Actonel, Aclasta or Fosavance) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure medication | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Antidepressant medications | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Steroid or corticosteroids(including prednisone) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Nitroglycerine | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Dilantin or anticonvulsants | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Blood thinners (plavix, heparin, coumadin, warfarin) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Birth control pill | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Insulin, metformin, tolbutamide | <input type="checkbox"/> | <input type="checkbox"/> |
| j. tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Do you take other medications: (please list below) | | |

10. Have you or are you currently undergoing any of the following medical procedures?

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. An artificial joint replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| b. An artificial heart valve placement | <input type="checkbox"/> | <input type="checkbox"/> |
| c. An organ transplant | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chemotherapy for cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Radiation therapy for cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pacemaker or defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Have you experienced complications due to treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

11. Have you or are you currently being treated for a mental illness? Yes No

To the best of my knowledge, all of the information provided above is true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medications or medical status change, I will inform the dentist at my next dental visit.

Date

Patient, Parent or Legal Guardians Name

Patient, Parent or Legal Guardians Signature

Date

Reviewed By

Reviewers Signature/Witness

