MEDICAL HISTORY

Patient Name_____ Physician Name_____

Last Medical Exam_____ Purpose_____

hospitalization for illness or injury? Why?When?_____

AN ALLERGIC REACTION TO:

- ◯ aspirin, ibuprofen, acetaminophen
- ◯ penicillin
- ◯ tetracycline
- ◯ codeine
- ◯ local anesthetic
- ◯ metals
- ◯ latex
- ◯ any other medications _____

WOULD YOU LIKE SOMEONE TO DISCUSS WITH YOU:

◯ Botox ◯ Dermal Fillers ◯ Cosmetic Dentistry

◯ Oral solutions for Sleep Apnea ◯ TMJ

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
heart problems	◯	◯
heart murmur	◯	◯
high blood pressure	◯	◯
low blood pressure	◯	◯
a stroke	◯	◯
artificial heart valve or joint	◯	◯
anemia or other blood disorder	◯	◯
prolonged bleeding w/slight cut	◯	◯
emphysema	◯	◯
tuberculosis	◯	◯
asthma	◯	◯
sleeping problems (i.e. snoring)	◯	◯
kidney disease	◯	◯
liver disease	◯	◯
thyroid or parathyroid disease	◯	◯
hormone deficiency	◯	◯
high cholesterol	◯	◯
diabetes	◯	◯
stomach or duodenal ulcer	◯	◯
osteoporosis (i.e. bisphosphonates)	◯	◯
arthritis	◯	◯
glaucoma	◯	◯
head or neck injuries	◯	◯
epilepsy, seizures, convulsions	◯	◯
neurologic problems	◯	◯
viral infections or cold sores	◯	◯
any lumps or swelling in mouth	◯	◯
hives, skin rash, hay fever	◯	◯
hepatitis (type___)	◯	◯
HIV/AIDS	◯	◯
tumor/abnormal growth/cancer	◯	◯
radiation therapy	◯	◯
chemotherapy	◯	◯
psychiatric treatment	◯	◯
alcohol/drug dependency	◯	◯
ARE YOU:		
presently being treated for any other illness	◯	◯
aware of a change in your general health	◯	◯
taking medication for weight management	◯	◯
often exhausted or fatigued	◯	◯
subject to frequent headaches	◯	◯
a smoker or smoked previously	◯	◯
FEMALE-taking birth control pills	◯	◯
FEMALE-pregnant	◯	◯
MALE-prostate disorder	◯	◯

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

_____

List of Medications, Supplements and Vitamins you are <u>currently</u> taking as prescribed or otherwise?

Drug	Drug	Drug
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____