

Patient Name _____ Name of Physician _____
 Specialty of Physician _____ Phone number of Physician _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

Do you have or have you ever had:	YES	NO		YES	NO
1. alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>	26. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	27. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Aspirin, ibuprofen, acetaminophen, codeine			28. an inhaler, nitroglycerin, an epi pen, or glucometer? If yes, bring to all appointments _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Erythromycin			29. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Fluoride			30. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Latex			31. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Local anesthetic			32. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Metals (nickel, gold, silver, _____)			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Penicillin			34. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Sulfa			35. osteoporosis/osteopenia (e.g., taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Tetracycline			36. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Other _____			37. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	38. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
4. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>	39. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
5. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>
6. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
7. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	42. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>
8. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. breathing or sleep problems (e.g., sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	44. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>
10. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>	45. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>
11. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>	46. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
12. diabetes (HbA1c= _____)	<input type="checkbox"/>	<input type="checkbox"/>	47. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
13. digestive disorders (e.g., celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you:		
14. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
15. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
16. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. heart problems or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	53. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
20. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	54. diagnosed with prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
21. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	56. considered a touchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
23. HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>	57. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
24. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>	58. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
25. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	59. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (e.g., Botox, Collagen Injections)

List all medications, supplements, and/or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 Signature _____ Date _____