Medical History

Last Name:	First name:	Middle:	Preferred Name:
Email address:			
Name of Physician:			
Date of last exam:	Purpose for last exam:		
What is the estimate of your general health? (please circle) Excellent Good Fair Poor			
Recent Hospitalization for illness or injury? Please explain...			
Describe any current medical treatment,impending surgery or other treatmens that may possibly affect your dental treatment			

PLEASE INDICATE IF YOU HAVE or HAVE EVER HAD THE FOLLOWING:

- ☐ **PREMEDICATE before procedures**
- ☐ Allergy-Acetaminophen
- ☐ Allergy-Codeine
- ☐ Allergy-Metals
- ☐ Allergy-Tetracycline
- ☐ Alzheimers
- ☐ Asthma
- ☐ Cerebral Palsy
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Surgery**
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Mitral Valve Prolapse**
- ☐ Radiation Treatment
- ☐ Seasonal Allergies
- ☐ Thyroid, Parathyroid
- ☐ OTHER (Explain below)
- ☐ Allergy-Local Anesthetic
- ☐ Allergy-Erythromycin
- ☐ Allergy-Morphine
- ☐ Artificial Heart Valve**
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Cold Sores/Viral Infections
- ☐ Epliepsy/Seizure Disorder
- ☐ Head or Neck Injuries
- ☐ Hepatitis (Type_____)
- ☐ Hormone Deficiency
- ☐ Liver Disease
- ☐ Neurologic Disorders
- ☐ Repaired Heart Defect**
- ☐ Sinus Problems
- ☐ Allergy-Aspirin
- ☐ Allergy-Ibuprofen
- ☐ Allergy-Penicillin
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Canver/Chemotherapy
- ☐ Diabetes
- ☐ Excessive/Porlong Bleeding
- ☐ Heart Disease**
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Stomach Ulcers
- ☐ Tumors
- ☐ Allergy-Cephalexin
- ☐ Allergy-Latex
- ☐ Allergy-Sulfa
- ☐ Angioplasty/Stents**
- ☐ Anxiety/Depression
- ☐ Cardiac Stent**
- ☐ Digestive (gastic reflux)
- ☐ Fainting
- ☐ Heart Murmur**
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Pacemaker**
- ☐ Rheumatic/Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis

If you have a condition that is not listed above,please make us aware. Knowing about other existing conditions will help us treat your dental needs

If you indicated any cardiac (heart) related issues above, please explain below:

DO YOU OR ARE YOU CURRENTLY EXPERIENCING?

- ☐ Wear contact lenses
- ☐ Breathing or Sleeping problems
- ☐ Do you snore or stop breathing while sleeping
- ☐ Do you wear CPAP or other appliance
- ☐ Presently being treated for any other illness
- ☐ Aware of any change in your general health
- ☐ Taking medication for weight management
- ☐ Taking general dietary supplements (vitamins)
- ☐ Often exhausted or fatigued
- ☐ Subject to frequent headaches
- ☐ Any lumps or swelling in the mouth
- ☐ A smoker? How long_____
- ☐ Previous smoker? How long_____
- ☐ Considered a touchy person
- ☐ Often unhappy or depressed
- ☐ In treatment for depression/emotional/psychiatric issues
- ☐ FEMALE-taking birth control
- ☐ FEMALE-pregnant? How many months_____
- ☐ MALE-prostate disorders

Please list all medications,supplements or vitamins you are currently taking or have taken in the last 2 years:

Patient Signature _____ Date _____