**MEDICAL HISTORY DATE:**

 **Patient Name: ­­­­ Nickname: Age:**

 **Name of Physician and their specialty:**

 **Most recent physical exam: Purpose:**

 **Hospitalizations:**

 **DO YOU HAVE or HAVE YOU EVER HAD?**

1. An allergic reaction to 18. Heart murmur Y N

 Aspirin, ibuprofen, acetaminophen 19. Heart problems Y N

 Codeine 20. Heart valve replacement Y N

 Erythromycin 21. Hepatitis (type ) Y N

 Fluoride 22. High blood pressure Y N

 Latex 23. High Cholesterol Y N

 Local anesthetic 24. HIV/AIDS Y N

 Metals (gold, stainless steel) 25. Hives/skin rash Y N

 Tetracycline, doxycycline, minocycline 26. Hormone deficiency Y N

 Penicillin/amoxicillin 27. Jaundice Y N

 Any other medications 28. Kidney disease Y N

 2. Alcohol/drug dependency Y N 29. Liver disease Y N

 3. Anemia or other blood disorder Y N 30. Low blood pressure Y N

 4. Arthritis Y N 31. Any lumps or swelling of the mouth Y N

 5. Artificial joint prosthesis (hip, knee, other, shoulder) Y N 32. Neurologic problems Y N

 6. Asthma Y N 33. Osteoporosis/osteopenia (taking bisphosphonates) Y N

 7. Breathing or sleeping problems (snoring) Y N 34. Prolonged bleeding after a cut or extraction Y N

 8. Cancer Y N 35. Psychiatric treatment Y N

 9. Metastatic cancer Y N 36. Radiation treatment Y N

 10. Chemotherapy Y N 37. Recent eye surgery Y N

 11. Cold sores/fever blister Y N 38. Stomach or duodenal ulcer Y N

 12. Diabetes (type ) Y N 39. Stroke Y N

 13. Digestive disorder (gastric reflux) Y N 40. Thyroid or parathyroid disease Y N

 14. Emphysema Y N 41. Tuberculosis Y N

 15. Epilepsy, convulsions (seizures) Y N 42. Tumor Y N

 16. Glaucoma Y N 43. Veneral Disease Y N

 17. Head or neck injury Y N

 **ARE YOU?**

 1. Presently being treated for any other illness Y N 9. Taking aspirin/blood thinner Y N

 2. Aware of a change in your general health Y N 10. Taking dietary supplements Y N

 3. Subject to frequent headaches Y N

 4. A smoker or previous smoker Y N 11. Taking herbal supplements

 5. Using smokeless tobacco Y N (garlic, ginkgo, ginseng, st. john’s wort) Y N

 6. FEMALE – taking birth control pills Y N 12. Previous periodontal treatment Y N

 7. FEMALE - pregnant (due date ) Y N 13. Family history of periodontal disease Y N

 8. MALE - prostate disorder Y N

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