**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.