Medical History Form

Please update your medical history, to the best of your ability. In doing this, you will provide our team with the information they need to provide the best possible care to you. Incorrect information could have serious negative effects on your oral and overall health.

MEDICAL HISTORY

[ ] Yes [ ] No Do you have a personal physician? *If yes, who:* _____

[ ] Yes [ ] No Do you go for yearly check-ups?

[ ] Yes [ ] No Have you had surgery or been hospitalized in the last two years?

If yes, why: _____

[ ] Yes [ ] No Have you taken any medications for Osteoporosis that contain bisphosphonates, like Fosamax?

If yes, what: _____

[ ] Yes [ ] No Are you on a special diet? *If yes, what:* _____

[ ] Yes [ ] No Do you have a family history of Diabetes?

[ ] Yes [ ] No Do you have a family history of Periodontal Gum Disease?

[ ] Yes [ ] No Do you use tobacco products? *If yes, what:* _____

[ ] Yes [ ] No Do you use controlled substances? *If yes, what:* _____

[ ] Yes [ ] No Do you need to pre-medicate with antibiotics prior to dental procedures?

If yes, what: _____

[ ] Yes [ ] No Do you have or have you had cancer? *If yes, what kind:* _____

[ ] Yes [ ] No Have you had chemotherapy treatment? *If yes, when:* _____

[ ] Yes [ ] No Have you had radiation treatment? *If yes, when:* _____

Women, are you:

[ ] Pregnant or trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives? [ ] Taking hormone replacement?

Are you allergic to any of the following?

[ ] Aspirin [ ] Metal [ ] Dairy Products [ ] Latex [ ] Sulfa Drugs [ ] Penicillin [ ] Acrylic

[ ] Other Antibiotics [ ] Codeine [ ] Local Anesthetics [ ] Other: _____

Please list any medications that you are currently taking:

_____

_____

Have you ever had any serious illness not listed? [ ] Y [ ] N *If so, explain:* _____

Do you currently have, or have you had, any of the following?

[ ] Yes [ ] No A-Fib / Irregular Heartbeat
[ ] Yes [ ] No Alzheimer's Disease
[ ] Yes [ ] No Anxiety
[ ] Yes [ ] No Blood Disease / Transfusion
[ ] Yes [ ] No Epilepsy / Seizures
[ ] Yes [ ] No Fainting Spells / Dizziness
[ ] Yes [ ] No Heart Pacemaker
[ ] Yes [ ] No High / Low Blood Pressure
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Pre-Diabetes / High Blood Sugar
[ ] Yes [ ] No Sinus Trouble
[ ] Yes [ ] No Thyroid Disease
[ ] Yes [ ] No AIDS / HIV Positive
[ ] Yes [ ] No Anaphylaxis
[ ] Yes [ ] No Arthritis / Gout
[ ] Yes [ ] No Congenital Heart Disorder
[ ] Yes [ ] No Excessive Dry Mouth
[ ] Yes [ ] No Frequent Cough
[ ] Yes [ ] No Heart Stents
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Lung Disease
[ ] Yes [ ] No Psychiatric Care
[ ] Yes [ ] No Sleep Apnea / CPAP
[ ] Yes [ ] No Tuberculosis
[ ] Yes [ ] No Acid Reflux / Heartburn
[ ] Yes [ ] No Anemia
[ ] Yes [ ] No Asthma
[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Excessive Snoring
[ ] Yes [ ] No Frequent Headaches
[ ] Yes [ ] No Heart Trouble / Disease
[ ] Yes [ ] No Hypoglycemia
[ ] Yes [ ] No Osteoporosis
[ ] Yes [ ] No Recent Weight Loss

[ ] Yes [ ] No Stomach / Intestinal Disease
[ ] Yes [ ] No Ulcers
[ ] Yes [ ] No Alcoholism / Drug Addiction
[ ] Yes [ ] No Angina / Chest Pains
[ ] Yes [ ] No Autoimmune Disease
[ ] Yes [ ] No Eating Disorder
[ ] Yes [ ] No Excessive Thirst
[ ] Yes [ ] No Glaucoma / Eye Disease
[ ] Yes [ ] No Herpes / Cold Sores / Fever Blisters
[ ] Yes [ ] No Kidney Disease
[ ] Yes [ ] No Pain in Jaw Joints / TMJ
[ ] Yes [ ] No Scarlet Fever
[ ] Yes [ ] No Stroke

[ ] Yes [ ] No Orthodontic Treatment
If so, when? _____
[ ] Yes [ ] No Popping or Cracking of the Jaw
[ ] Yes [ ] No Clenching or Grinding of Teeth
[ ] Yes [ ] No Occlusal Guard / Bite Splint

If yes to the following, please explain:

[ ] Yes [ ] No Artificial Heart Valve
_____
[ ] Yes [ ] No Heart Attack / Failure
_____
[ ] Yes [ ] No Heart Murmur
_____
[ ] Yes [ ] No Mitral Valve Prolapse
_____
[ ] Yes [ ] No Rheumatic Fever
_____
[ ] Yes [ ] No Artificial Joint
_____
[ ] Yes [ ] No Hepatitis A, B, or C
_____