Medical History

Patient name: ________________________________ nickname______________ Date: _________

Physician's name:________________________________ Most recent physical exam:______________

Purpose: ____

Estimate your current health status: excellent___ good ___ fair ___ poor ___

Do you have or have ever had:	Yes	No
1. Hospitalization for illness or injury	Yes	No
2. An allergic reaction to:		
aspirin, ibuprofen, acetaminophen, codeine	Yes	No
penicillin	Yes	No
erythromycin	Yes	No
tetracycline	Yes	No
sulfa	Yes	No
local anesthetic	Yes	No
fluoride	Yes	No
metals (nickel, gold, silver)	Yes	No
Latex	Yes	No
Other______________	Yes	No
3. Heart problems, or cardiac stent in the last 6 months	Yes	No
4. History of endocarditis	Yes	No
5. Artificial heart valve, repaired heart defect (PFO)	Yes	No
6. Pacemaker or defibrillator	Yes	No
7. Artificial prosthesis, WHEN?_________	Yes	No
8. Low blood pressure	Yes	No
9. High blood pressure	Yes	No
10. A stroke	Yes	No
11. Anemia or other blood disorder	Yes	No
12. Digestive disorders (i.e. gastric reflux)	Yes	No
13. Emphysema, sarcoidosis	Yes	No
14. Tuberculosis	Yes	No
15. Asthma	Yes	No
16. Breathing or sleep problems (i.e. snoring)	Yes	No
17. kidney disease	Yes	No
18. Liver disease	Yes	No
19. Diabetes	Yes	No
20. Thyroid disease	Yes	No
21. Hormone deficiency	Yes	No
22. High cholesterol	Yes	No
23. Anxiety	Yes	No
24. Depression	Yes	No
25. ADHD	Yes	No
26. Osteoporosis/osteopenia	Yes	No
27. Arthritis	Yes	No
28. Head or neck injury	Yes	No
29. Epilepsy, convulsions (seizures)	Yes	No
30. Radiotherapy / Chemotherapy	Yes	No
31. Tumor, abnormal growth	Yes	No
32. HIV / AIDS	Yes	No
33. Viral infections and cold sores	Yes	No
34. Any lumps or swelling in the mouth	Yes	No
35. Hives, skin rash, hay fever	Yes	No
36. STI / STD	Yes	No
37. Hepatitis	Yes	No
38.Rheumatic or scarlet fever	Yes	No

ARE YOU:

43. User of marijuana	Yes	No
44. User of alcohol	Yes	No
45. A smoker or Vaper	Yes	No
46. User of smokeless tobacco	Yes	No
47. Take blood thinners	Yes	No
48. Take bisphosphonates (alendronate)	Yes	No

______________________________ Patient Signature

______________________________ Doctor's Signature

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