Medical History

Patient's Name_____
Name of *medical doctor*_____
Date of last physical _____

Name of *previous dentist*_____

Date of last exam_____

	Yes	No
*Are you currently under the care of a physician? If so, for what? _____	☐	☐
* Has there been any change in your health within the past year? _____	☐	☐
*Have you ever had or been diagnosed with:		
Infective endocarditis	☐	☐
Congenital heart defect	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
High cholesterol	☐	☐
Prosthetic joint surgery	☐	☐
Prosthetic heart valve	☐	☐
Heart surgery	☐	☐
Pacemaker/defibrillator	☐	☐
Anticoagulant therapy	☐	☐
Heart attack	☐	☐
Organ transplant	☐	☐
Emphysema/sarcoidosis	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Anemia	☐	☐
Blood problems	☐	☐
Leukemia	☐	☐
Diabetes (HbA1c=____)	☐	☐
Thyroid disorder	☐	☐
Ulcer, colitis	☐	☐
Hepatitis	☐	☐
Liver disease	☐	☐
Kidney trouble	☐	☐
Arthritis, Rheumatism	☐	☐
Malignancies/cancer	☐	☐
Chemotherapy	☐	☐
Venereal disease	☐	☐
Epilepsy/convulsions	☐	☐
Neurological issues	☐	☐
Drug/alcohol dependency	☐	☐
Excessive bleeding(INR>3.5)	☐	☐
Stroke (blood thinners?)	☐	☐
Corticosteroid therapy	☐	☐
Fainting spells, convulsions	☐	☐
Psychiatric care	☐	☐
Head & neck radiation	☐	☐
Eye disorder (glaucoma)	☐	☐
Hormone therapy	☐	☐
HIV/AIDS	☐	☐

	Yes	No
Have you ever taken the drug Fen-Phen?	☐	☐
Do you have osteoporosis?	☐	☐
Have you ever taken bisphosphonates such as: Fosamax, Actonel, Aredia, Zometa, Boniva, Didronel, Skelial, etc to prevent bone loss from osteoporosis?	☐	☐
Do you have any disease, condition or problem not listed? _____		
Do you wear, or have you worn a **CPAP**?	☐	☐
Do you snore or have sleep apnea?	☐	☐
Do you often feel exhausted or fatigued?	☐	☐
Do you have any specific dental concerns	☐	☐
If so, what_____		
Any lumps or swelling in the mouth?	☐	☐
Would you like to keep your remaining teeth?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Amount _____How many years_____		

For Women:

Is there any chance you could be pregnant?	☐	☐
Are you taking birth control pills?	☐	☐

Please list any and all medications you are taking, including herbal supplements?

Drug	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

* Any known **allergies**?	☐	☐
Specifically, Penicillin	☐	☐
Sulfa	☐	☐
Latex	☐	☐

*****Signature (patient or parent/guardian)**

_____**Date**_____