MEDICAL HISTORY

(This medical history is strictly confidential and only used for the diagnosis and treatment of dental diseases.)

All personal information will be shredded after use.

Name				**Date**			
Allergies				**DOB**			
Weight	Lbs	**Height**	' "	**Pulse**		**Blood pressure** (to be taken by Dental Assistant)	

MEDICATIONS	**PREVIOUS DENTAL TREATMENT**	**AREAS OF CONCERN for today**

GENERAL HEALTH INFORMATION	**Y**	**N**
Are you currently being treated by a physician?	☐	☐
If yes, for what condition?		
Do you or have you had any of the following?		
Fatigue / Tire easily	☐	☐
Fever / Chills / Night Sweats	☐	☐
Recent weight change	☐	☐
Organ transplant candidate	☐	☐
Other general symptoms information:		

HEAD, EYES, EARS, NOSE, THROAT (HEENT)	**Y**	**N**
Have you been diagnosed with any of the following conditions?		
Head injury	☐	☐
Vision problems ☐glaucoma ☐cataracts ☐Other	☐	☐
Hearing impairment	☐	☐
Allergic rhinitis	☐	☐
Chronic sinusitis	☐	☐
Please list other HEENT diagnoses information:		
Do you presently suffer from any of the following?		
Bleeding gums	☐	☐
Cold sores / mouth ulcers	☐	☐
Ear problems ☐ringing ☐earaches ☐chronic infections ☐other	☐	☐
Frequent headaches / migraines	☐	☐
Frequent sore throat	☐	☐
Hoarseness	☐	☐
Please check ☐nasal stuffiness ☐discharge ☐frequent nose bleeds	☐	☐
Swelling of the neck / glands	☐	☐
Vision problems ☐blurry vision ☐dry eyes ☐other	☐	☐
Hearing aid	☐	☐
Contact lenses or glasses	☐	☐
Other HEENT symptoms information:		

CARDIOVASCULAR	Y	N
Have you been diagnosed with any of the following conditions?		
Infective endocarditis	☐	☐
Coronary artery disease	☐	☐
Heart attack	☐	☐
If yes, specify date (month & year) of attack		
Congestive heart failure	☐	☐
Hypertension	☐	☐
Atrial fibrillation	☐	☐
Heart Block	☐	☐
Cardiac arrhythmia	☐	☐
Please check ☐pacemaker ☐implanted defibrillator	☐	☐
Please check ☐rheumatic fever ☐rheumatic heart disease	☐	☐
Heart murmur	☐	☐
If yes, please check ☐with regurgitation ☐without regurgitation		
Mitral valve prolapse (MVP)	☐	☐
Deep vein thrombosis (DVT)	☐	☐
Stroke (CVA)	☐	☐
If yes, specify last occurrence date (month / year)		
Please list other cardiovascular diagnoses information:		
Do you presently suffer from any of the following?		
Shortness of breath on minimal exertion	☐	☐
Shortness of breath on lying down without pillows under the head / back	☐	☐
Palpitations	☐	☐
Angina / Chest pain	☐	☐
Dizziness / Light headedness	☐	☐
Swelling of the ankles or feet	☐	☐
Please list other cardiovascular symptoms information:		

RESPIRATORY	Y	N
Have you been diagnosed with any of the following conditions?		
Chronic bronchitis or emphysema	☐	☐
Asthma / Hyperactive airway disease	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
If yes, please check ☐active ☐inactive		
Please list other respiratory diagnoses information:		
Do you presently suffer from any of the following?		
Chest pain exacerbated by deep breathing	☐	☐
Cough	☐	☐
If yes, please check all that apply. ☐dry ☐productive ☐sputum ☐pus ☐blood		
Difficulty breathing	☐	☐
Please check ☐sleep apnea ☐snoring	☐	☐
Wheezing	☐	☐
Other general symptoms information:		

RENAL & GENITOURINARY	Y	N
Have you been diagnosed with any of the following conditions?		
Renal failure / Insufficiency	☐	☐
Kidney stones	☐	☐
Currently undergoing dialysis	☐	☐
If yes, please check ☐Monday, Wednesday, & Friday ☐Tuesday, Thursday, & Saturday		
Other renal or genitourinary diagnoses or symptoms information:		

GASTROINTESTINAL	Y	N
Have you been diagnosed with any of the following conditions?		
Hepatitis / Jaundice	☐	☐
If yes, Hepatitis, please check ☐A ☐B ☐C ☐D		
Stomach or duodenal ulcer	☐	☐
Crohn's disease	☐	☐
Colitis	☐	☐
Cirrhosis / Liver disease	☐	☐
Gastroesophogeal reflux disease	☐	☐
Other gastrointestinal diagnoses information:		
Do you presently suffer from any of the following?		
Heartburn	☐	☐
Difficulty swallowing	☐	☐
Vomiting	☐	☐
If yes, please check ☐food ☐bile ☐blood ☐other		
Other gastrointestinal symptoms information:		

ENDOCRINOLOGICAL	Y	N
Have you been diagnosed with any following conditions?		
Diabetes	☐	☐
If yes, please check ☐Type I ☐Type II		
other (please list)		
Date of diagnosis (year) and a brief description:		
Date of last visit to diabetes physician:		
Last glycated hemoglobin (A1c value):		
Do you routinely check blood sugar with a glucometer?	☐	☐
Last glucometer reading:		
Thyroid disorder	☐	☐
What Type of thyroid disorder? ☐hyper thyroidism ☐hypo thyroidism ☐other		
Adrenal gland disorder	☐	☐
Steroids taken within the last 2 years	☐	☐
Please list other hormonal diagnoses or symptoms information:		
Do you presently suffer from (have) any of the following?		
Frequent thirst How many glasses/bottles of water per day?	☐	☐
Frequent urination Do you have to get up 3x or more during the night? If so, how often?	☐	☐

Frequent hunger, or after large meal still feel hungry?	☐	☐
Do you have a first degree relative with diabetes?	☐	☐
☐ Mother ☐ Father ☐Brother ☐Sister	☐	☐
Have you been informed about how diabetes my affect your oral health?	☐	☐
If female, did you ever have diabetes during pregnancy?	☐	☐

HEMATOLOGICAL	**Y**	**N**
Have you been diagnosed with any of the following conditions?		
Bleeding Disorders	☐	☐
Hemophilia A	☐	☐
Hemophilia B	☐	☐
Von Willebrands	☐	☐
Idiopathic Thrombocytopenic Purpura (ITP)	☐	☐
Medication-induced bleeding	☐	☐
Please list other bleeding disorder diagnoses information:		

HEMATOLOGICAL (continued)	**Y**	**N**
Blood Disorders:		
Iron deficiency anemia	☐	☐
Sickle cell ☐Disease ☐Trait	☐	☐
Thallesemia	☐	☐
Please list other blood disorder diagnoses information:		
Blood Transfusion	☐	☐
If yes, please check ☐Before 1987 ☐After 1987		
Please list other hematologic diagnoses or symptoms information:		

MUSCULOSKELETAL	**Y**	**N**
Have you been diagnosed with any following conditions?		
Arthritis	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
Please list other musculoskeletal conditions:		
Artificial joints / implants	☐	☐
Please list other musculoskeletal diagnoses or symptom information:		

NEUROLOGICAL/PSYCHIATRIC	**Y**	**N**
Have you been diagnosed with any of the following conditions?		
Epilepsy / Other seizure disorder	☐	☐
If yes, please check ☐grand mal ☐partial seizure ☐petit mal ☐other seizure disorder		
Cerebral palsy	☐	☐
Mental Retardation	☐	☐
If yes, please check ☐mild ☐moderate ☐severe ☐profound		
Autism	☐	☐
Depression	☐	☐
Attention deficit disorder / Attention deficit hyperactive disorder	☐	☐
Alzheimer's disease / Dementia	☐	☐
Anxiety disorder	☐	☐
Please list other neurological / psychiatric diagnoses information:		

Do you presently suffer from any of the following?		
Weakness	☐	☐
Numbness / Tingling	☐	☐
Please list other neurological / psychiatric symptoms information:		

DERMATALOGICAL		
Have you been diagnosed with any skin conditions?		
Do you presently suffer from any skin problems?	☐	☐
If so, please check all that apply. ☐skin cancer ☐other, please specify:		
Please list other skin diagnoses/symptom information:		

IMMUNOLOGICAL	Y	N
Received organ transplant	☐	☐
If yes, please specify date of transplant (month/year) and type		
Have you been diagnosed with an autoimmune disease?	☐	☐
If yes, please check ☐Hashimoto's Thyroiditis ☐Grave's disease ☐Systemic Lupus Erythematosus (SLE) ☐multiple sclerosis ☐rheumatoid arthritis ☐Sjogren's syndrome ☐other		

INFECTIOUS DISEASE	Y	N
Have you been diagnosed with any sexually transmitted disease (STD)?	☐	☐
If yes, please check type: ☐Syphilis ☐HIV ☐Herpes ☐other		
Description of infectious disease (s):		

ONCOLOGICAL	Y	N
Have you been diagnosed with cancer?	☐	☐
If yes, please check type: ☐bone ☐lymphoma ☐prostate/testicular		
Please list other types of cancer:		
Have you ever had radiotherapy?	☐	☐
If yes, list location and dates performed:		
Have you ever had chemotherapy?	☐	☐
If yes, list dates (mo. / yr.) & description of chemotherapy:		

OBSTETRICAL/GYNECOLOGICAL	Y	N
Pregnant or think you might be pregnant?	☐	☐
If pregnant, approximate due date:		
Are you currently trying to get pregnant?	☐	☐
Are you breast-feeding?	☐	☐

SURGICAL HISTORY		

	Y	N
Undergone any surgery(ies):	☐	☐
If yes, please list the type of surgery, date (month / year) of surgery, and outcome of surgery.		

MEDICATIONS	Y	N
Are you currently taking any medications?	☐	☐
Please list prescriptions:		
over the counter products:		
herbal products:		
other supplements:		

MEDICATIONS (continued)	Y	N
Have you ever taken any bisphosphonates, diet pills or steroids?	☐	☐

If yes, please check all that apply:

☐Zometa ☐Boniva ☐Aredia ☐Didronel ☐Actonel

☐Fosamax ☐Fen-Phen ☐Pondin/Redux ☐Oral or IV Steroids ☐Skelid

Please list other medications:

ALLERGIES	Y	N
Do you have any allergies to (Please check all that apply):	☐	☐

☐Aspirin/NSAIDS ☐codeine ☐cosmetics ☐foods ☐latex

☐local anesthesia ☐metals ☐penicillin/other antibiotics ☐sulfa drugs

Please list other allergy information:

FAMILY HISTORY	Y	N
Do you have any diseases or medical problems that run in your family? Please check all that apply.	☐	☐

☐arthritis ☐diabetes ☐cancer ☐heart attack

☐heart disease ☐high blood pressure ☐stroke ☐other, please

SOCIAL HISTORY	Y	N
Do you or have you ever consumed alcohol?	☐	☐

What type? ☐beer ☐wine ☐hard liquor

If yes, how often do you consume alcohol?

☐rarely ☐occasionally ☐often ☐frequently & excessively

Do you or have you ever used tobacco?	☐	☐

☐cigarettes ☐cigars ☐pipe ☐smokeless

# of years you have used tobacco?

Do you or have you ever used recreational drugs?	☐	☐

If yes, please check all that apply:

☐inhaled ☐intravenous ☐oral ☐marijuana

☐cocaine ☐crystal methamphetamine ☐heroin ☐other, please

Other recreational drug information:

OTHER MEDICAL HISTORY	Y	N
Is there anything else in your past medical history or present medical status that we should know or you would like to discuss?	☐	☐
Please list the items you wish to discuss:		
Do you require antibiotic prophylaxis?	☐	☐
Other family history information:		