



## **MEDICAL HISTORY FORM**

Thank you for downloading our comprehensive Medical History Form!

This form represents an important adjunct to your dental exam because it not only creates improved oral literacy but acts as a system checker. Understanding the why behind each question and what it means for patient risk management will fundamentally change your practice and elevate the dental experience for your patients.

Every single question has been carefully created and incorporates annually updated research, patient psychology, neurology, and pharmacology. This sets the stage for both the immediate issues and a more long-term focus on predictable treatment outcomes.

The binary layout of the questions takes emotion out of the patient risk assessment allowing for scientifically supported facts to supply successful, predictable, repeatable outcomes for both simple and complex restorative cases.

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?                      Excellent                      Good                      Fair                      Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**                      YES NO                      YES NO

1. hospitalization for illness or injury \_\_\_\_\_
2. an allergic or bad reaction to any of the following:
  - aspirin, ibuprofen, acetaminophen, codeine \_\_\_\_\_
  - penicillin \_\_\_\_\_
  - erythromycin \_\_\_\_\_
  - tetracycline \_\_\_\_\_
  - sulfa \_\_\_\_\_
  - local anesthetic \_\_\_\_\_
  - fluoride \_\_\_\_\_
  - chlorhexidine (CHX) \_\_\_\_\_
  - Iodine \_\_\_\_\_
  - metals (nickel, gold, silver, \_\_\_\_\_ )
  - latex \_\_\_\_\_
  - nuts \_\_\_\_\_
  - fruit \_\_\_\_\_
  - milk \_\_\_\_\_
  - red dye \_\_\_\_\_
  - other \_\_\_\_\_
3. heart problems, or cardiac stent within the last six months \_\_\_\_\_
4. history of infective endocarditis \_\_\_\_\_
5. artificial heart valve, repaired heart defect (PFO) \_\_\_\_\_
6. pacemaker or implantable defibrillator \_\_\_\_\_
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) \_\_\_\_\_
8. heart murmur, rheumatic or scarlet fever \_\_\_\_\_
9. high or low blood pressure \_\_\_\_\_
10. a stroke (taking blood thinners) \_\_\_\_\_
11. anemia or other blood disorder \_\_\_\_\_
12. prolonged bleeding due to a slight cut (or INR > 3.5) \_\_\_\_\_
13. pneumonia, emphysema, shortness of breath, sarcoidosis \_\_\_\_\_
14. chronic ear infections, tuberculosis, measles, chicken pox \_\_\_\_\_
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) \_\_\_\_\_
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) \_\_\_\_\_
17. kidney disease \_\_\_\_\_
18. liver disease or jaundice \_\_\_\_\_
19. vertigo (e.g. "the room is spinning") \_\_\_\_\_
20. thyroid, parathyroid disease, or calcium deficiency \_\_\_\_\_
21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) \_\_\_\_\_
22. high cholesterol or taking statin drugs \_\_\_\_\_
23. diabetes (HbA1c = \_\_\_\_\_ ) \_\_\_\_\_
24. stomach or duodenal ulcer \_\_\_\_\_
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) \_\_\_\_\_

26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) \_\_\_\_\_
27. arthritis or gout \_\_\_\_\_
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) \_\_\_\_\_
29. glaucoma \_\_\_\_\_
30. contact lenses \_\_\_\_\_
31. head or neck injuries \_\_\_\_\_
32. epilepsy, convulsions (seizures) \_\_\_\_\_
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) \_\_\_\_\_
34. viral infections and cold sores \_\_\_\_\_
35. any lumps or swelling in the mouth \_\_\_\_\_
36. hives, skin rash, hay fever \_\_\_\_\_
37. STI/STD/HPV \_\_\_\_\_
38. hepatitis (type \_\_\_\_\_ ) \_\_\_\_\_
39. HIV/AIDS \_\_\_\_\_
40. tumor, abnormal growth \_\_\_\_\_
41. radiation therapy \_\_\_\_\_
42. chemotherapy, immunosuppressive medication \_\_\_\_\_
43. emotional difficulties \_\_\_\_\_
44. psychiatric treatment or antidepressant medication \_\_\_\_\_
45. concentration problems or ADD/ADHD \_\_\_\_\_
46. alcohol/recreational drug use \_\_\_\_\_

**ARE YOU:**

47. presently being treated for any other illness \_\_\_\_\_
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) \_\_\_\_\_
49. taking medication for weight management \_\_\_\_\_
50. taking dietary supplements, vitamins, and/or probiotics \_\_\_\_\_
51. often exhausted or fatigued \_\_\_\_\_
52. experiencing frequent headaches or chronic pain \_\_\_\_\_
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) \_\_\_\_\_
54. considered a touchy/sensitive person \_\_\_\_\_
55. often unhappy or depressed \_\_\_\_\_
56. taking birth control pills \_\_\_\_\_
57. currently pregnant \_\_\_\_\_
58. diagnosed with a prostate disorder \_\_\_\_\_

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) \_\_\_\_\_

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_