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**

1. hospitalization for illness or injury ____________
2. an allergic reaction to ____________
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ____________)
   - latex
   - 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 implant (joint replacement) ____________
8. 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 (INR > 3.5) ____________
13. emphysema, shortness of breath, sarcoidosis ____________
14. tuberculosis, measles, chicken pox ____________
15. asthma ____________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________
18. liver disease ____________
19. jaundice ____________
20. thyroid, parathyroid disease, or calcium deficiency ____________
21. hormone deficiency ____________
22. high cholesterol or taking statin drugs ____________
23. diabetes (HbA1c = _______) ____________
24. stomach or duodenal ulcer ____________
25. digestive disorders (i.e. celiac disease, gastric reflux) ____________
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __

YES NO

27. arthritis ____________
28. autoimmune disease ____________
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________
30. contact lenses ____________
31. head or neck injuries ____________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, 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 ____________
45. antidepressant medication ____________
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
    (i.e. fever, chills, new cough, or diarrhea) ____________
49. taking medication for weight management ____________
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches ____________
53. a smoker, smoked previously or use smokeless tobacco _
54. considered a touchy / sensitive person ____________
55. often unhappy or depressed ____________
56. taking birth control pills ____________
57. currently pregnant ____________
58. prostate disorders ____________

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, and or vitamins 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 ____________

Please email completed forms to office@drfootedental.com or mellony@drfootedental.com

ASA ______ **(1-6)**

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