Medical History Form

Name:____ **Physician Name:**____________________________________

Physician Address & Phone Number:____

Estimate of your overall health: **Excellent** ◯ **Good** ◯ **Fair** ◯ **Poor** ◯

Do you have OR have you ever had:

	YES	NO
• Hospitalization for illness/injury:_______________	◯	◯
• A reaction (allergic or otherwise) to:		
○ Aspirin, Ibuprofen, Acetaminophen	◯	◯
○ Codeine	◯	◯
○ Penicillin and/or Amoxicillin	◯	◯
○ Clindamycin	◯	◯
○ Erythromycin	◯	◯
○ Tetracycline	◯	◯
○ Sulpha	◯	◯
○ Local Anaesthetic	◯	◯
○ Fluoride	◯	◯
○ Metals (nickel, gold, silver, ___________)	◯	◯
○ Other (please list): ____________________	◯	◯
• Heart attack, arrhythmia or stent (Date:__________)	◯	◯
• History of infective endocarditis	◯	◯
• Rheumatic fever	◯	◯
• Artificial heart valve OR repaired heart defect	◯	◯
• Pacemaker OR implantable defibrillator	◯	◯
• High OR Low blood pressure (circle which)	◯	◯
• Stroke	◯	◯
• Anemia OR other blood disorder	◯	◯
• Prolonged bleeding due to a slight cut	◯	◯
• Artificial joint (i.e. hip, knee)	◯	◯
• Asthma, COPD, emphysema OR sarcoidosis (circle)	◯	◯
• Tuberculosis	◯	◯
• Breathing or sleep problems (snoring, apnea)	◯	◯
○ If yes, have you had a sleep study?	◯	◯
• Kidney disease	◯	◯
• Liver disease OR jaundice	◯	◯
• Thyroid OR parathyroid disease (circle which)	◯	◯
• Hormone imbalance	◯	◯
• High cholesterol (or taking statin drugs)	◯	◯
• Diabetes (Type:_______)	◯	◯
• Stomach or duodenal ulcer	◯	◯
• Gastroesophageal (“acid”) reflux	◯	◯
• Inflammatory bowel disease	◯	◯
• Glaucoma	◯	◯
• Osteoporosis	◯	◯
• Arthritis	◯	◯

	YES	NO
• Head or neck injury	◯	◯
• Epilepsy, convulsions or seizures	◯	◯
• Neurologic disorder (i.e. Alzheimer’s, MS, Parkinson’s)	◯	◯
• Behavioural disorder (i.e. ADHD, Autism Spectrum Disorder)	◯	◯
• Herpes infections or cold sores	◯	◯
• Lumps or swelling in the mouth	◯	◯
• Hives, skin rashes, hay fever	◯	◯
• Sexually Transmitted Infection	◯	◯
• Hepatitis (Type:_________)	◯	◯
• HIV / AIDS	◯	◯
• Tumor, cyst or other growth	◯	◯
• Cancer (Type:____________________________)	◯	◯
• Chemotherapy, radiation OR both (circle)	◯	◯
• Emotional or psychiatric issues	◯	◯
• Alcohol or drug dependency	◯	◯
○ Substance:__________________________		
○ Time since last use:__________________		

Are you:

	YES	NO
• Subject to frequent headaches	◯	◯
• Subject to jaw pain	◯	◯
• Subject to fainting spells	◯	◯
• Taking/using any recreational drugs	◯	◯
○ If yes, list:___________________________		
• A smoker (or smoked previously)	◯	◯
○ If yes, amount and frequency:___________		
• Vaping or using chewing tobacco	◯	◯
• Taking dietary supplements	◯	◯
○ If yes, list:___________________________		
• FEMALE:		
○ Taking birth control pills	◯	◯
○ Pregnant or trying to get pregnant	◯	◯
• MALE:		
○ Dealing with a prostate disorder/dysfunction	◯	◯
• Being treated for any illness not listed:	◯	◯
○ If yes, describe:_______________________		

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

Drug	Purpose	Drug	Purpose
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient Signature:_________________________________ Date:__________________________