

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:

1. Hospitalization for illness or injury ☐ Y ☐ N

2. An allergic or bad reaction to any of the following: ☐ Y ☐ N

- ☐ 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 ☐ Y ☐ N

4. History of infective endocarditis ☐ Y ☐ N

5. Artificial heart valve, repaired heart defect (PFO) ☐ Y ☐ N

6. Pacemaker or implantable defibrillator ☐ Y ☐ N

7. Orthopedic or soft tissue implant
(e.g., joint replacement, breast implant) ☐ Y ☐ N

8. Heart murmur, rheumatic or scarlet fever ☐ Y ☐ N

9. High or low blood pressure ☐ Y ☐ N

10. A stroke (taking blood thinners) ☐ Y ☐ N

11. Anemia or other blood disorder ☐ Y ☐ N

12. Prolonged bleeding due to a slight cut (or INR > 3.5) ☐ Y ☐ N

13. Pneumonia, emphysema, shortness of breath, sarcoidosis ☐ Y ☐ N

14. Chronic ear infections, tuberculosis, measles, chicken pox ☐ Y ☐ N

15. Breathing problems (e.g., asthma, stuffy nose, sinus congestion) ☐ Y ☐ N

16. Sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) ☐ Y ☐ N

17. Kidney disease ☐ Y ☐ N

18. Liver disease or jaundice ☐ Y ☐ N

19. Vertigo (e.g., "the room is spinning") ☐ Y ☐ N

20. Thyroid, parathyroid disease, or calcium deficiency ☐ Y ☐ N

21. Hormone deficiency or imbalance
(e.g., polycystic ovarian syndrome) ☐ Y ☐ N

22. High cholesterol or taking statin drugs ☐ Y ☐ N

23. Diabetes (HbA1c = _____) ☐ Y ☐ N

24. Stomach or duodenal ulcer ☐ Y ☐ N

25. Digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) ☐ Y ☐ N

26. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) ☐ Y ☐ N

27. Arthritis or gout ☐ Y ☐ N

28. Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ☐ Y ☐ N

29. Glaucoma ☐ Y ☐ N

30. Contact lenses ☐ Y ☐ N

31. Head or neck injuries ☐ Y ☐ N

32. Epilepsy, convulsions (seizures) ☐ Y ☐ N

33. Neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) ☐ Y ☐ N

34. Viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) ☐ Y ☐ N

35. Any lumps or swelling in the mouth ☐ Y ☐ N

36. Hives, skin rash, hay fever ☐ Y ☐ N

37. STI/STD/HPV ☐ Y ☐ N

38. Hepatitis (type _____) ☐ Y ☐ N

39. HIV/AIDS ☐ Y ☐ N

40. Tumor, abnormal growth ☐ Y ☐ N

41. Radiation therapy ☐ Y ☐ N

42. Chemotherapy, immunosuppressive medication ☐ Y ☐ N

43. Difficulties with stress management ☐ Y ☐ N

44. Psychiatric treatment, antidepressants, mood stabilizing medications ☐ Y ☐ N

45. Concentration problems or ADD/ADHD ☐ Y ☐ N

46. Alcohol/recreational drug use ☐ Y ☐ N

ARE YOU:

47. Presently being treated for any other illness ☐ Y ☐ N

48. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ☐ Y ☐ N

49. Taking medication for weight management ☐ Y ☐ N

50. Taking dietary supplements, vitamins, and/or probiotics ☐ Y ☐ N

51. Often exhausted or fatigued ☐ Y ☐ N

52. Experiencing frequent headaches or chronic pain ☐ Y ☐ N

53. A smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) ☐ Y ☐ N

54. considered a touchy/sensitive person ☐ Y ☐ N

55. often unhappy or depressed ☐ Y ☐ N

56. taking birth control pills ☐ Y ☐ N

57. currently pregnant ☐ Y ☐ N

58. diagnosed with a prostate disorder ☐ Y ☐ N

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 (YOU MAY ALSO USE THE BACK OF THIS FORM)

Drug _____ Purpose _____

Drug _____ Purpose _____

Drug _____ Purpose _____

Drug _____ Purpose _____

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 _____

Dentist's Signature _____ Date _____