

daniel daniel

DENTISTRY

MEDICAL HISTORY

Name: _____ Age: _____

Family Doctor's name: _____

Most recent Physical: _____ Purpose: _____

Your estimate of your overall general health? Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING:

ALLERGIC REACTION TO:

- | | | |
|--|--|---|
| <input type="radio"/> Aspirin | <input type="radio"/> Ibuprofen | <input type="radio"/> Rheumatic fever |
| <input type="radio"/> Acetaminophen | <input type="radio"/> Penicillin | <input type="radio"/> Scarlet fever |
| <input type="radio"/> erythromycin | <input type="radio"/> Tetracycline | <input type="radio"/> Sinus problems |
| <input type="radio"/> codeine | <input type="radio"/> Local anesthetic | <input type="radio"/> Stomach ulcer |
| <input type="radio"/> fluoride | <input type="radio"/> Metals (gold, stainless steel) | <input type="radio"/> Stroke |
| <input type="radio"/> Latex | <input type="radio"/> Other: _____ | <input type="radio"/> Thyroid disease |
| <input type="radio"/> Alcohol / drug dependency | <input type="radio"/> Heart problems | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Anemia or other blood disorder | <input type="radio"/> Hepatitis (type __) | <input type="radio"/> Tumor / abnormal growth |
| <input type="radio"/> Antidepressant medication | <input type="radio"/> High blood pressure | <input type="radio"/> Viral infections / cold sores |
| <input type="radio"/> Arthritis | <input type="radio"/> High cholesterol | <input type="radio"/> Hospitalization for injury or illness |
| <input type="radio"/> Artificial prosthesis | <input type="radio"/> HIV / AIDS | |
| <input type="radio"/> Asthma | <input type="radio"/> Hives, skin rash, hay fever | <u>ARE YOU CURRENTLY</u> |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hormone deficiency | <input type="radio"/> Presently being treated for any illness |
| <input type="radio"/> Contact lenses | <input type="radio"/> Jaundice | <input type="radio"/> Aware of a change in your health |
| <input type="radio"/> Diabetes | <input type="radio"/> Kidney disease | <input type="radio"/> Often exhausted or fatigued |
| <input type="radio"/> Emotional problems | <input type="radio"/> Liver disease | <input type="radio"/> Subject to frequent headaches |
| <input type="radio"/> Emphysema | <input type="radio"/> Low blood pressure | <input type="radio"/> A heavy smoker |
| <input type="radio"/> Epilepsy | <input type="radio"/> Lumps or swelling in mouth | <input type="radio"/> Often unhappy or depressed |
| <input type="radio"/> Glaucoma | <input type="radio"/> Prolonged bleeding due to slight cut | <input type="radio"/> Easily upset or irritated |
| <input type="radio"/> Head or neck injuries | <input type="radio"/> Psychiatric treatment | <input type="radio"/> FEMALE – pregnant |
| <input type="radio"/> Heart murmur | <input type="radio"/> Radiation | <input type="radio"/> Male – Prostate disorders |

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List any medications, herbal supplements, and/or vitamins taken within the last two years

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

Signature

Date