MEDICAL HISTORY

Today's Date: _____

Patient Name: _____

Patient date of birth: _____

Physician name and phone number: _____

Date of most recent physical examination: _____

What is the estimate of your general health: Excellent Good Fair Poor

1. Have you ever been hospitalized for illness or injury? If yes, please explain: _____

2. Please circle from the list below, if you have had, or do have an allergy, or allergic reaction to the following:

Aspirin, ibuprofen, acetaminophen, codeine	Penicillin	erythromycin
Tetracycline	Sulfa	Local anesthetic
Fluoride	Metals (nickel, gold, silver)	

If allergy is not listed above, please list here: _____

3. Do you have or have you had heart problems, (example; artificial valve, pacemaker) please explain and provide dates of any surgeries: _____

PLEASE CIRCLE FROM THE LIST BELOW, IF YOU HAVE HAD, OR DO HAVE ANY OF THE LISTED CONDITIONS:

4. **~history of infective endocarditis~**	5. **~repaired heart defect, congenital heart disease~**	6. **pacemaker, or implantable defibrillator**
7. **~artificial prosthesis (i.e. heart valve, joint replacement)~**	8. rheumatic or scarlet fever	9. high or low blood pressure
10. stroke (taking blood thinners)	11. anemia or other blood disorder	12. prolonged bleeding (INR>3.5)
13. emphysema, short of breath, sarcoidosis	14 tuberculosis, measles, chicken pox	15. asthma
16. breathing or sleeping problems	17. kidney disease/dialysis	18. liver disease
19. jaundice	20. thyroid or calcium deficiency	21. hormone deficiency
22. high cholesterol	23. diabetes	24. stomach, or duodenal ulcer
25. digestive disorders	26. osteoporosis/osteopenia	27. arthritis, rheumatoid arthritis, lupus
28. glaucoma	29. contact lenses	30. head or neck injuries
31. epilepsy, convulsions (seizures)	32. neurologic disorders (ADHD, prion disease)	33. viral infections and cold sores
34. any lumps or swelling in the mouth	35. hives, skin rash, hay fever	36. STI/STD
37. Hepatitis-type:	38. HIV/AIDS	39. tumor, abnormal growth
40. radiation therapy	41. chemotherapy, immunosuppressive	42. emotional problems
43. psychiatric treatment	44. antidepressant medication	45. alcohol/street drug use/addiction

ARE YOU:

46. Presently being treated for any other illness_____

47. Aware of a change in your health in the last 24 hours (i.e. fever, chills, cough, diarrhea)_____

_____

48. Taking medications for weight management (i.e. fen-phen)_____
49. Taking dietary supplements_____
50. Often exhausted or fatigued_____
51. Experiencing frequent headaches_____
52. A smoker, smoked previously, or uses smokeless tobacco_____
53. Considered a touchy person_____
54. Often unhappy or depressed_____
55. FEMALE-taking birth control_____
56. FEMALE-pregnant_____
57. MALE-prostate disorders_____
58. Blood transfusions_____
59. Cancer_____
60 Are you or have you ever taken Fosamax, Boniva, Actonel, or any other medications containing biophosphates_____

Please describe any other health conditions, current medical treatments, impending surgeries, or developmental delays not listed_____

_____

Medications

List all medications and their purposes taken within the last two years. Please include supplements and or vitamins:_____

_____

_____

Signature of Patient, Parent, or Guardian: X_____

Today's Date:_____