Medical History

Holmes FAMILY & COSMETIC DENTISTRY
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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:	NO	YES
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	○	○
6. pacemaker or implantable defibrillator	○	○
7. orthopedic implant (joint replacement)	○	○
8. rheumatic or scarlet fever	○	○
9. high blood pressure	○	○
10. a stroke	○	○
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 =_____)	○	○

	NO	YES
24. stomach or duodenal ulcer	○	○
25. digestive disorders (i.e. celiac disease, gastric reflux)	○	○
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	○	○
27. arthritis	○	○
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	○	○
29. glaucoma	○	○
30. head or neck injuries	○	○
31. epilepsy, convulsions (seizures)	○	○
32. neurologic disorders (ADD/ADHD, prion disease)	○	○
33. viral infections and cold sores	○	○
34. any lumps or swelling in the mouth	○	○
35. hives, skin rash, hay fever	○	○
36. sexually tranismitted disease, HIV, or HPV	○	○
37. hepatitis (type _____)	○	○
38. HIV / AIDS	○	○
39. tumor, abnormal growth	○	○
40. radiation therapy	○	○
41. chemotherapy, immunosuppressive medication	○	○
42. psychiatric treatment	○	○
43. antidepressant medication	○	○
44. alcohol / recreational drug use	○	○
ARE YOU:		
45. presently being treated for any other illness	○	○
46. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	○	○
47. taking medication for weight management	○	○
48. taking dietary supplements	○	○
49. often exhausted or fatigued	○	○
50. experiencing frequent headaches	○	○
51. a smoker, smoked previously or use smokeless tobacco	○	○
52. often unhappy or depressed	○	○
53. currently pregnant	○	○

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: _____

SUBMIT