Medical History Form - Oliver Dental Care

Medical Alert

Patient Name: _____

Date of Birth - Month_____ Day_____Year_____

What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

DO YOU HAVE OR HAVE YOU EVER HAD...

		Y	N
1.	hospitalization for illness or injury.....	☐	☐
2.	an allergic or bad reaction to any of the following...		
	☐ aspirin, ibuprofen, acetaminophen, codeine		
	☐ penicillin		
	☐ erythromycin		
	☐ tetracycline		
	☐ sulfa		
	☐ local anesthetic		
	☐ fluoride		
	☐ metals (nickel, gold, silver, _____)		
	☐ latex		
	☐ chlorhexidine (CHX)		
	☐ nuts		
	☐ fruit		
	☐ milk		
	☐ red dye		
	☐ other _____		
3.	heart problems, or a cardiac stent in last six months	☐	☐
4.	a history of infective endocarditis.....	☐	☐
5.	an artificial heart valve, repaired heart defect (PFO)...	☐	☐
6.	pacemaker or implantable defibrillator.....	☐	☐
7.	orthopedic or soft tissue implant (joint replacement, breast implant)	☐	☐
8.	heart murmur, rheumatic or scarlet fever….....	☐	☐
9.	high or low blood pressure.....	☐	☐
10.	a stroke (taking blood thinners).....	☐	☐
11.	anemia or other blood disorder.....	☐	☐
12.	prolonged bleeding due to a slight cut (INR>3.5).....	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis.	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox..	☐	☐
15.	breathing problems (asthma, stuffy nose, sinus congestion)….	☐	☐
16.	sleep problems (sleep apnea, snoring, sinus).	☐	☐
17.	kidney disease.....	☐	☐
18.	liver disease or jaundice.....	☐	☐
19.	vertigo (e.g., “the room is spinning”).....	☐	☐
20.	thyroid, parathyroid disease or calcium deficiency.....	☐	☐
21.	hormone deficiency or imbalance (e.g., PCOS).....	☐	☐
22.	high cholesterol or taking statin drugs.....	☐	☐
23.	diabetes (HbA1c=_____).....	☐	☐
24.	stomach or duodenal ulcer.....	☐	☐
25.	digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia).....	☐	☐
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates)…	☐	☐
27.	arthritis or gout.....	☐	☐
28.	autoimmune disease (rheumatoid arthritis, lupus, scleroderma)	☐	☐

		Y	N
29.	glaucoma…….....	☐	☐
30.	contact lenses……..	☐	☐
31.	head or neck injuries……	☐	☐
32.	epilepsy, convulsions (seizures).....	☐	☐
33.	neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34.	viral infections and cold sores.....	☐	☐
35.	any lumps or swelling in the mouth.....	☐	☐
36.	hives, skin rash, hay fever.....	☐	☐
37.	STI / STD / HPV.....	☐	☐
38.	hepatitis (type _____).....	☐	☐
39.	HIV / AIDS.....	☐	☐
40.	tumour, abnormal growth.....	☐	☐
41.	radiation therapy.....	☐	☐
42.	chemotherapy, immunosuppressive medication..	☐	☐
43.	emotional difficulties.....	☐	☐
44.	psychiatric treatment or antidepressant medication..	☐	☐
45.	concentration problems or ADD/ADHD diagnosis	☐	☐
46.	alcohol/recreational drug use.....	☐	☐
47.	Speech difficulties or delayed growth at any time.	☐	☐
ARE YOU...			
48.	presently being treated for any other illness.....	☐	☐
49.	aware of a change in your health in the last 24 hours? (fever, chills, new cough, or diarrhea).....	☐	☐
50.	taking medication for weight management.....	☐	☐
51.	taking dietary supplements.....	☐	☐
52.	often exhausted or fatigued.....	☐	☐
53.	experiencing frequent headaches or chronic pain	☐	☐
54.	a smoker, smoked previously or use smokeless tobacco……	☐	☐
55.	considered a touchy or sensitive person.....	☐	☐
56.	often unhappy or depressed.....	☐	☐
57.	taking birth control pills…….....	☐	☐
58.	currently pregnant……..	☐	☐
59.	diagnosed with a prostate disorder……	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delays or any other possible treatment that might affect your dental treatment: _____

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:_____

I, the undersigned, certify that all of the medical information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

Patient's Signature: _____Date: _____ Dentist's Signature: _____Date:_____

☐ *Patient* ☐*Parent* ☐*Legally Authorized Representative* ASA: _____ (1-6)