West Wind DENTAL

Medical History

Date: _____ Patient Name: _____ Age: _____

Name of Physician & their specialty: _____

Date of 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:	YES	NO
1. Hospitalization for illness/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 problem or cardiac stent in last 6 months		
4. History of infective endocarditis		
5. Artificial heart valve, repaired heart defect (PFO)		
6. Pacemaker or implantable defibrillator		
7. Orthopedic implant (joint replacement)		
8. Rheumatic or scarlet fever		
9. High or low blood pressure		
10. Stroke (taking blood thinners)		
11. Anemia or blood disorder		
12. Prolonged bleeding due to slight cut (INR>3.5)		
13. Emphysema, shortness of breath, sarcoidosis		
14. Tuberculosis, measles, chicken pox		
15. Asthma		
16. Breathing or sleep problems		
17. Kidney Disease		
18. Liver Disease		
19. Jaundice		
20. Thyroid, parathyroid disease or calcium deficiency		

	YES	NO
21. Hormone deficiency		
22. High cholesterol or taking statin drugs		
23. Arthritis		
24. Autoimmune disease		
25. Glaucoma		
26. Contact lenses		
27. Head or neck injuries		
28. Epilepsy, convulsions (seizures)		
29. Neurologic disorder (ADD/ADHD, prion disease		
30. Viral infection, cold sores		
31. Lumps or swelling in mouth		
32. Hives, rash, hay fever		
33. STI/STD/HPV		
34. Hepatitis (Type: _____)		
35. HIV/AIDS		
36. Tumor, abnormal growth		
37. Radiation therapy		
38. Chemotherapy, immunosuppressive medications		
39. Emotional difficulties		
40. Psychiatric treatment		
41. Antidepressant medication		
42. Alcohol/recreational drug use		
43. Diabetes (HbA1c=_____)		
44. Stomach or duodenal ulcer		
45. Digestive disorders (Celiac, gastric reflux, etc)		
46. Osteoporosis/osteopenia (i.e. taking bisphosphonates)		

ARE YOU:	YES	NO		YES	NO
1. Presently being treated for any illness			7. A smoker, smoked previously, use		
2. Aware of change in your health in the last 24 hr (fever, chills, cough, diarrhea)			smokeless tobacco, or a history of vaping or marijuana use		
3. Taking meds for weight management			8. Considered a sensitive/touchy person		
4. Taking dietary supplements			9. Often unhappy/depressed		
5. Often exhausted/fatigued			10. Taking birth control pills		
6. Experiencing frequent headaches			11. Currently Pregnant		
			12. Prostate disorders		

Please describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment: _____
_____

Please list all medications, supplements and vitamins taken within the past 2 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: _____