4th Avenue Dental Centre

MEDICAL HISTORY

Patient Name _____

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:

	YES	NO
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		
○ chlorhexidine (CHX)		
○ iodine		
○ metals (nickel, gold, silver, titanium,)		
○ latex		
○ nuts		
○ fruit		
○ milk		
○ red dye		
○ other		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker, implantable defibrillator, or organ transplant	☐	☐
7. orthopedic or soft tissue implant (e.g., joint replacement)	☐	☐
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 (or INR > 3.5)	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15. breathing problems	☐	☐
16. sleep problems	☐	☐
17. kidney disease	☐	☐
18. liver disease or jaundice	☐	☐
19. vertigo	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency or imbalance	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c = _____)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive or eating disorders	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates)	☐	☐
27. arthritis or gout	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions	☐	☐
33. neurologic disorders (e.g., Alzheimer's, dementia, prion disease)	☐	☐
34. viral infections	☐	☐
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. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. difficulties with stress management	☐	☐
44. psychiatrictreatment,antidepressants	☐	☐
45. concentration problems or ADD/ADHD	☐	☐
46. alcohol/recreational drug use	☐	☐

ARE YOU:

	YES	NO
47. presently being treated for any other illness	☐	☐
aware of a change in your health in the last 24 hours	☐	☐
48. taking medication for weight management		
49. taking dietary supplements, vitamins, and/or	☐	☐
50. probiotics	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches or chronic pain	☐	☐
53. a smoker, smoked previously or other	☐	☐
54. considered a touchy/sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant or breastfeeding	☐	☐
58. diagnosed with a prostate disorder	☐	☐

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, vitamins, and/or probiotics 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 _____