PITTSFORD SMILES DENTAL PC
GENERAL & SPECIALIZED DENTISTRY

MEDICAL HISTORY

Patient Name_____ Age_____
Name of Physician/and their specialty _____ PHONE: _____
Most recent physical examination Purpose_____ What is your estimate of your general health? O Excellent O Good O Fair O Poor

DO YOU HAVE or HAVE YOU EVER HAD:

__ YES__NO 1. hospitalization for illness or injury __
__ YES__NO 2. an allergic or bad reaction to any of the following:
__ aspirin, __ ibuprofen, __ acetaminophen, __codeine __penicillin __ erythromycin __ tetracycline
__sulfa __ local anesthetic __ fluoride__chlorhexidine (CHX) __metals (nickel, gold, silver,)__ latex
__nuts__ fruit __ other

__ YES__NO 3. heart problems, or cardiac stent within the last six months
__ YES__NO 4. history of infective endocarditis
__ YES__NO 5. artificial heart valve, repaired heart defect (PFO)
__ YES__NO 6. pacemaker or implantable defibrillator
__ YES__NO 7. orthopedic implant (joint replacement)
__ YES__NO 8. rheumatic or scarlet fever
__ YES__NO 9. high or low blood pressure
__ YES__NO 10. a stroke (taking blood thinners)
__ YES__NO 11. anemia or other blood disorder
__ YES__NO 12. prolonged bleeding due to a slight cut (INR > 3.5)
__ YES__NO 13. pneumonia, emphysema, shortness of breath, sarcoidosis
__ YES__NO 14. chronic ear infections, tuberculosis, measles, chicken pox
__ YES__NO 15. asthma
__ YES__NO 16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus)
__ YES__NO 17. kidney disease
__ YES__NO 18. liver disease
__ YES__NO 19. jaundice
__ YES__NO 20. thyroid, parathyroid disease, or calcium deficiency
__ YES__NO 21. hormone deficiency
__ YES__NO 22. high cholesterol or taking statin drugs
__ YES__NO 23. diabetes (HbA1c =)
__ YES__NO 24. stomach or duodenal ulcer
__ YES__NO 25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia)
__ YES__NO 26. osteoporosis/osteopenia (e.g., taking bisphosphonates)
__ YES__NO 27. arthritis
__ YES__NO 28. autoimmune disease(e.g., rheumatoid arthritis, lupus, scleroderma)
__ YES__NO 29. glaucoma
__ YES__NO 30. contact lenses
__ YES__NO 31. head or neck injuries
__ YES__NO 32. epilepsy, convulsions (seizures)
__ YES__NO 33. neurologic disorders (ADD/ADHD, prion disease)
__ YES__NO 34. viral infections and cold sores
__ YES__NO 35. any lumps or swelling in the mouth
__ YES__NO 36. hives, skin rash, hay fever
__ YES__NO 37. STI/STD/HPV
__ YES__NO 38. hepatitis (type)
__ YES__NO 39. HIV/AIDS
__ YES__NO 40. tumor, abnormal growth
__ YES__NO 41. radiation therapy
__ YES__NO 42. chemotherapy, immunosuppressive medication
__ YES__NO 43. emotional difficulties
__ YES__NO 44. psychiatric treatment
__ YES__NO 45. antidepressant medication
__ YES__NO 46. alcohol/recreational drug use

ARE YOU:

__ YES__NO 47. presently being treated for any other illness
__ YES__NO 48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)
__ YES__NO 49. taking medication for weight management
__ YES__NO 50. taking dietary supplements
__ YES__NO 51. often exhausted or fatigued
__ YES__NO 52. experiencing frequent headaches
__ YES__NO 53. ___ a smoker, ___ smoked previously or
___ use smokeless tobacco
__ YES__NO 54. considered a touchy/sensitive person
__ YES__NO 55. often unhappy or depressed
__ YES__NO 56. taking birth control pills
__ YES__NO 57. currently pregnant
__ YES__NO 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, and or vitamins taken within the last two years

DRUG	DOSE	PURPOSE

PATIENT SIGNATURE_____ DATE_____
PROVIDER SIGNATURE _____ DATE_____