PDE center
PITTSFORD DENTAL EXCELLENCE
Elevating Dentistry to an Art Form

Medical History

Patient Name:_____ Nickname:_____ Age:_____

Name of physician and their specialty:_____

Most recent physical exam:_____ 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 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 with the last 6 months	◯	◯
4. History of infective endocarditis_____	◯	◯
5. Artificial heart valve or repaired hear defect (PFO)__	◯	◯
6. Pacemaker if implantable defibrillator_____	◯	◯
7. Artificial prosthesis (heart valve or joints)_____	◯	◯
8. 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 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=_____)_____	◯	◯
24. Stomach or duodenal ulcer_____	◯	◯
25. Digestive disorders (i.e. celiac disease, gastric reflux)	◯	◯

	YES	**NO**
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	◯	◯
27. Arthritis, rheumatoid arthritis, Lupus_____	◯	◯
28. Glaucoma_____	◯	◯
29. Contact lenses_____	◯	◯
30. Head or neck injuries_____	◯	◯
31. Epilepsy, convulsions (seizures)_____	◯	◯
32. Neurologic disorders (ASS/ADHD, prion disease)____	◯	◯
33. Viral infections or cold sores_____	◯	◯
34. Any lumps or swelling in mouth_____	◯	◯
35. Hives, skin rash, hay fever_____	◯	◯
36. STI/STD_____	◯	◯
37. Hepatitis (type _____)_____	◯	◯
38. HIV/AIDS_____	◯	◯
39. Tumor, abnormal growth_____	◯	◯
40. Radiation therapy_____	◯	◯
41. Chemotherapy, immunosuppressive_____	◯	◯
42. Emotional problems_____	◯	◯
43. Psychiatric treatment_____	◯	◯
44. Antidepressant medication_____	◯	◯
45. Alcohol/street drug use_____	◯	◯
ARE YOU:		
46. Presently being treated for any other illness_____	◯	◯
47. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough or diarrhea)_	◯	◯
48. Taking medication for weight management (i.e. fen-phen)_	◯	◯
49. Taking dietary supplements_____	◯	◯
50. Often exhausted or fatigued_____	◯	◯
51. Experiencing frequent headaches_____	◯	◯
52. A smoker, smoked previously or use smokeless tobacco___	◯	◯
53. Considered a touchy person_____	◯	◯
54. Often unhappy or depressed_____	◯	◯
55. **FEMALE:** Taking birth control pills_____	◯	◯
56. **FEMALE:** Pregnant_____	◯	◯
57. **MALE:** Prostate disorders_____	◯	◯

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 2 years

Drug	**Purpose**	**Drug**	**Purpose**

Ask for an additional sheet if you are taking more than 6 medications.

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:_____