MEDICAL HISTORY

Patient Name_____ Nickname _____ Age_____

Name of Physician and 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		Yes	No		Yes	No
Hospitalization for illness or injury	☐	☐	Kidney disease	☐	☐	Neurologic Problems	☐	☐
Heart problem	☐	☐	Liver disease	☐	☐	Viral infections and cold sores	☐	☐
Heart murmur	☐	☐	Jaundice	☐	☐	Any lumps/swelling in the mouth	☐	☐
Rheumatic Fever	☐	☐	Thyroid or Parathyroid disease	☐	☐	Hives, skin rash, hay fever	☐	☐
Scarlet Fever	☐	☐	Hormone deficiency	☐	☐	Venereal disease	☐	☐
High blood pressure	☐	☐	High Cholesterol	☐	☐	Hepatitis (type_____)	☐	☐
Low blood pressure	☐	☐	Diabetes	☐	☐	HIV/AIDS	☐	☐
A stroke	☐	☐	Stomach or duodenal ulcer	☐	☐	Tumor/abnormal growth	☐	☐
Artificial prosthesis (i.e. heart valve or joints)	☐	☐	Digestive disorders	☐	☐	Radiation therapy	☐	☐
Anemia or other blood disease	☐	☐	Osteoporosis/Osteopenia	☐	☐	Chemotherapy	☐	☐
Prolonged bleeding due to a slight cut	☐	☐	Arthritis	☐	☐	Emotional Problems	☐	☐
Emphysema	☐	☐	Glaucoma	☐	☐	Psychiatric treatment	☐	☐
Tuberculosis	☐	☐	Contact Lenses	☐	☐	Antidepressant medication	☐	☐
Asthma	☐	☐	Head or neck injuries	☐	☐	Alcohol/drug dependency	☐	☐
Breathing/Sleep problems (i.e. snoring, sinus)	☐	☐	Epilepsy/Convulsions (seizures)	☐	☐			

ARE YOU:

	Yes	No		Yes	No
Presently being treated for any other illness	☐	☐	A smoker or smoked previously	☐	☐
Aware of a change in your general weight	☐	☐	Often unhappy or depressed	☐	☐
Taking medication for weight management	☐	☐	Often exhausted or fatigued	☐	☐
Taking dietary supplements	☐	☐	Subject to frequent headaches	☐	☐
FEMALE - pregnant	☐	☐	MALE – prostate disorders	☐	☐
FEMALE – taking birth control pills	☐	☐			

ALLERGIC REACTION TO:

	Yes	No
Penicillin	☐	☐
Erythromycin	☐	☐
Tetracycline	☐	☐
Codeine	☐	☐
Local Anesthetic	☐	☐
Fluoride	☐	☐
Acetaminophen	☐	☐
Latex	☐	☐
Aspirin	☐	☐
Metals (type_____)	☐	☐
Ibuprofen	☐	☐
Any other medication _____	☐	☐

G.A.S.P. Questionnaire

	Yes	No	Not Sure
Have you been told (or noticed on your own)that you snore on most nights?	☐	☐	☐
Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?	☐	☐	☐
Are you tired, fatigued or sleepy on most days?	☐	☐	☐
Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	☐	☐	☐
Are you overweight?	☐	☐	☐

☐ Yes Total +	☐ Not sure Total =	☐	0	1	2	3	4	5
			Low Risk		Medium Risk		High Risk	

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List any medications, supplements and or vitamins 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

Signature_____ Date_____

Relationship to Patient _____