General Medical History

Name:_____

Birth Date:_____

1. Current Medical Status (Good, Fair, Poor)
Please Explain:_____
_____
_____
_____

2. Are you being treated for any Medical Conditions? (YES NO) Please give details:

Condition: _____ **Treatment:** _____

Condition: _____ **Treatment:** _____

Condition: _____ **Treatment:** _____

Condition: _____ **Treatment:** _____

3. Please list all current Prescription, Non-Prescription Medications, Vitamins, Herbal Remedies, or other Medications:

_____ _____
_____ _____
_____ _____
_____ _____

4. Have you taken Cortisone or Steroid Medication (Prednisone, etc.) in the last year? (YES NO)
Please Explain:_____
_____
_____
_____

5. Have you ever had a Major Illness or have been Hospitalized? (YES NO)

Illness: _____ **Year:** _____
Illness: _____ **Year:** _____
Illness: _____ **Year:** _____
Illness: _____ **Year:** _____

6. Have you any Skin, Respiratory, Food Allergies or Sensitivities? (YES NO)

Please Explain:_____
_____
_____
_____

7. Have you any Allergies, Sensitivities, or any Unusual Reactions to Local Anesthetics or any Medications? Or warned against the use of any Drug or Medication? (YES NO)
Please Explain:_____
_____
_____
_____

8. Please check any of the following problems that you have, or have had:

a. **Heart and Blood Vessels**
   - ◊ high blood pressure (hypertension)
   - ◊ disorders of the heart valves (heart murmur, scarlet fever, rheumatic fever, infective endocarditis, mitral valve prolapse)
   - ◊ coronary artery disease (angina, congestive heart failure, pulmonary edema, heart attack)
   - ◊ irregular heart rate or rhythm
   - ◊ diseases of the heart muscle or pericardium
   - ◊ circulatory problems
   - ◊ cardiac or vascular surgery

b. **Brain and Nervous System**
   - ◊ stroke or transient ischemic attack
   - ◊ degenerative disorders (Alzheimer's, cerebral palsy)
   - ◊ infections and meningitis
   - ◊ epilepsy, seizures, convulsions, tics
   - ◊ problems of the spine or peripheral nerves

c. **Blood**
   - ◊ anemias
   - ◊ leukemias
   - ◊ lymphomas
   - ◊ bleeding disorders (hemophilia)

d. **Lungs and Respiratory System**
   - ◊ respiratory infections (bronchitis, tuberculosis)
   - ◊ chronic lung conditions (asthma, emphysema, cystic fibrosis)

e. **Endocrine System**
   - ◊ pancreatic disorders (diabetes mellitus, hyperglycemia, hypoglycemia)
   - ◊ thyroid disorders (hyperthyroidism, hypothyroidism)
   - ◊ malignant hyperthermia
   - ◊ adrenal gland disorders
   - ◊ pituitary gland disorders
   - ◊ parathyroid disorders

f. **Gastrointestinal System**
   - ◊ esophogeal problems
   - ◊ stomach problems (indigestion, ulcer, gastritis, tumor)
   - ◊ disorders of the small and large intestine
   - ◊ liver disease (jaundice, hepatitis A/B/C, cirrhosis)
   - ◊ gall bladder, bile duct disorders

g. **Genitourinary System**
   - ◊ kidney disorders, injury, and infections
   - ◊ bladder problems

h. **Neuromuscular and Skeletal Systems**
   - ◊ **joint disorders (arthritis, rheumatism)**
   - ◊ **osteoporosis**
   - ◊ **muscle and tendon disorders**
   - ◊ **soft tissue disorders**

i. **Ears, Nose, Throat**
   - ◊ **disorders of the ears (tinitis, infection)**
   - ◊ **disorders of the sinus**
   - ◊ **disorders of the nose**
   - ◊ **disorders of the throat**

j. **Eyes**
   - ◊ **impaired vision**
   - ◊ **other eye disorders**

k. **Mental**
   - ◊ **psychological, psychiatric conditions**
   - ◊ **mental impairment**

l. **Infectious Diseases**
   - ◊ **common contagious diseases (colds, flu)**
   - ◊ **Tuberculosis**
   - ◊ **Mononucleosis**
   - ◊ **sexually transmitted diseases**
   - ◊ **HIV infection, AIDS**
   - ◊ **other infectious diseases**

m. **Cancer**
   - ◊ **surgery**
   - ◊ **radiation**
   - ◊ **chemotherapy**

n. **Organ Transplant**

o. **Medical Implants**
   - ◊ **joint replacement**
   - ◊ **heart valve replacement**
   - ◊ **pacemaker**
   - ◊ **indwelling catheter**
   - ◊ **dental implant**
   - ◊ **other**

p. Symptoms Review

- ◊ **swollen ankles, chest pain, shortness of breath**
- ◊ **bruise easily, frequent nosebleeds**
- ◊ **persistent cough, blood in sputum**
- ◊ **changes in appetite, weight gain or loss**
- ◊ **tendency to faint**
- ◊ **fever**
- ◊ **pain**
- ◊ **temperature intolerance**
- ◊ **troubles with hearing or balance (dizziness)**
- ◊ **impaired vision**

q. Women only

- ◊ **pregnancy**
- ◊ **birth control pills**
- ◊ **estrogen replacement therapy**

r. Family History of Diseases and Conditions.

Please List: _____

_____

s. Misuse, overuse, or abuse of substances

- ◊ **drugs**
- ◊ **tobacco**
- ◊ **alcohol**
- ◊ **other**

t. Is there any other information not covered in the above medical history that may affect your dental treatment?

(YES NO)

Please Explain:_____

_____

_____

_____

I the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

Patient's Name: _____ **Date: (dd/mm/yy):** _____

Patient Signature:_____ **Doctor Signature:** _____