Nathan Bird, DMD, PLLC
Family Dentistry

MEDICAL HISTORY

Patient Name ____ Nickname _____________________ Age __________

Name of Physician/and their specialty ____

Most recent physical examination ____

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 within the last 6 months	___	___
4. History of infective endocarditis	___	___
5. Artificial heart valve, repaired heart defect (PFO)	___	___
6. Pacemaker or implantable defibrillator	___	___
7. Orthopedic implant (joint replacement)	___	___
8. Rheumatic or scarlet fever	___	___
9. High or low blood pressure	___	___
10. A stroke (taking blood thinner)	___	___
11. Anemia or other blood disorder	___	___
12. Prolonged bleeding due to a slight cut (INR > 3.5)	___	___
13. Emphysema, shortness of breath, sarcoidosis	___	___
14. Tuberculosis, measles, chicken pox	___	___
15. Asthma	___	___
16. Breathing or sleep problems (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 disorder (celiac disease, gastric reflux)	___	___
26. Osteoporosis/osteopenia (taking bisphosphonates)	___	___

	Yes	No
27. Arthritis	___	___
28. Autoimmune Disease	___	___
29. Glaucoma	___	___
30. Contact lenses	___	___
31. Head or neck injuries	___	___
32. Epilepsy, convulsions, seizures	___	___
33. Neurologic disorders (ADD/ADHD, prion)	___	___
34. Viral infections and cold sores	___	___
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	___	___
43. Emotional Difficulties	___	___
44. Psychiatric treatment	___	___
45. Antidepressant Medication	___	___
46. Alcohol or recreational drug use	___	___
ARE YOU:		
47. Presently being treated for illness	___	___
48. Change in health in the last 24 hours (ie fever, chills, new cough, diarrhea)	___	___
49. Using medication for weight	___	___
50. Taking dietary supplements	___	___
51. Often exhausted or fatigued	___	___
52. Experiencing frequent headaches	___	___
53. Past/current smoker/smokeless tobacco	___	___
54. Considered a touchy/sensitive person	___	___
55. Often unhappy or depressed	___	___
56. Taking birth control pills	___	___
57. Currently Pregnant	___	___
58. Prostate disorders	___	___

Describe current medical treatment, impending surgery, genetic/development delay, or other treatment that may affect your dental treatment. (ie Botox, Collagen injections) ____

List all medications, supplements, and or vitamins taken within the last two years.

Drug: ____________________ Purpose: _________________ Drug: _________________ Purpose: ________________

Drug: ____________________ Purpose: _________________ Drug: _________________ Purpose: ________________

Patient's Signature ____ Date __________________________________

Doctor's Signature ____ Date __________________________________

Please advise us in the future of any change in your medical history or any medications you may be taking. ASA ______ (1-6)