4M DENTAL IMPLANT CENTER

Medical History

Last Name_____ First Name_____ Birthdate_____

Name of Physician/their specialty_____

Most recent physical examination_____ Purpose_____

Name of Pharmacy/phone #/address_____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1. hospitalization for illness or injury_____ yes no
2. an allergic reaction to_____ yes no
   - 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_____ 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 slight cut (INR>3.5)_____ yes no
13. emphysema, shortness of breath, sarcoidosis_____ yes no
14. tuberculosis, measles, chicken pox_____ yes no
15. asthma_____ yes no
16. breathing or sleeping problems(i.e. sleep apnea)_____ 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 disorders (i.e. celiac disease, gastric reflux)___yes no
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)__yes no
27. arthritis_____ yes no
28. autoimmune disease_____ yes no
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma_____ yes no
30. contact lenses_____ yes no
31. head or neck injuries_____ yes no
32. epilepsy, convulsions (seizures)_____ yes no
33. neurological 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_____ yes no

ARE YOU:

47. presently being treated for any other illnesses_____ yes no
48. aware of a change in your health in the past 24 hours___ yes no
    (i.e. 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, or used 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. prostate disorders_____ yes no

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	Purpose	Drug	Purpose

PLESE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

_____ _____

Parent/Guardian Signature Date: Doctor Signature Date: