ALLISON O'BRIEN DMD

MEDICAL HISTORY

Patient Name ______________________________ Preferred ______________ DOB________

Address____

Telephone (____)________________ SSN_____/_____/_____ Email____________________________

EmergencyContact/Number____

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. heart problems or heart surgery ______________	☐	☐
2. artificial joints or joint surgeries______________	☐	☐
3. high or low blood pressure ______________	☐	☐
4. anemia or other blood disorder ______________	☐	☐
5. prolonged bleeding due to a slight cut (NR>3.5) ______	☐	☐
6. shortness of breath, sarcoidosis ______________	☐	☐
7. tuberculosis, measles, chicken pox ______________	☐	☐
8. asthma ______________	☐	☐
9. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)_	☐	☐
10. kidney disease ______________	☐	☐
11. liver disease ______________	☐	☐
12. thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
13. hormone deficiency ______________	☐	☐
14. high cholesterol or taking statin drugs ______________	☐	☐
15. diabetes (HbA1c=_______) ______________	☐	☐
16. stomach or duodenal ulcer ______________	☐	☐
17. digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐
18. hospitalization for illness or injury ______________	☐	☐

19. please list any allergies to foods, drugs, or anything else:

____

____

____

	YES	NO
20. osteoporosis/osteopenia (i.e. taking bishosphonates) _____	☐	☐
21. arthritis, rheumatoid arthritis, lupus ______________	☐	☐
22. glaucoma ______________	☐	☐
23. head or neck injuries ______________	☐	☐
24. epilepsy, convulsions (seizures) ______________	☐	☐
25. neurologic disorders (ADD/ADHD, prion disease) ________	☐	☐
26. viral infections and cold sores ______________	☐	☐
27. any lumps or swelling in the mouth ______________	☐	☐
28. hives, skin rash, hay fever ______________	☐	☐
29. STI/STD ______________	☐	☐
30. hepatitis (type ___) ______________	☐	☐
31. HIV / AIDS ______________	☐	☐
32. tumor, abnormal growth ______________	☐	☐
33. radiation therapy ______________	☐	☐
34. chemotherapy, immunosuppressive ______________	☐	☐
35. psychiatric treatment ______________	☐	☐
36. alcohol / street drug use ______________	☐	☐

ARE YOU:

	YES	NO
37. presently being treated for any other illness ____________	☐	☐
38. often exhausted or fatigued ______________	☐	☐
39. experiencing frequent headaches ______________	☐	☐
40. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
41. FEMALE - pregnant ______________	☐	☐

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

____

List all 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.

Patient's Signature ____________________________________ Date ______________

Doctor's Signature ____________________________________ Date ______________