# Main Med History Designer Smiles(25)

Patient Name: Birth Date: Date Created:

| | | | |
|---|---|---|---|
| Name of Physician/and their specialty | ☐ | If yes | |
| Most recent physical examination | ☐ | If yes | |
| Purpose | ☐ | If yes | |

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, ER, Walk-in. ◯ Yes ◯ No

2. an allergic reaction to

| | | | | | |
|---|---|---|---|---|---|
| aspirin, ibuprofen, acetaminophen, codei | ◯ Yes ◯ No | penicillin | ◯ Yes ◯ No | erythromycin | ◯ Yes ◯ No |
| tetracycline | ◯ Yes ◯ No | sulfa | ◯ Yes ◯ No | local anesthetic | ◯ Yes ◯ No |
| fluoride | ◯ Yes ◯ No | metals (nickel, gold, silver, others lis | ◯ Yes ◯ No | latex | ◯ Yes ◯ No |
| Other Allergies? List below | ◯ Yes ◯ No | | | | |

HAVE or EVER HAD continued ...

| | | | | | |
|---|---|---|---|---|---|
| 3. heart issue or cardic stent (last 6 m | ◯ Yes ◯ No | 4. history of infective endocarditis | ◯ Yes ◯ No | 5. repaired heart valve defect (PFO) | ◯ Yes ◯ No |
| 6. pacemaker/implantable defibrillator | ◯ Yes ◯ No | 7. artificial prosthesis (List | ◯ 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-slight cut (INR>3 | ◯ Yes ◯ No | 13. emphysema, sarcoidosis | ◯ Yes ◯ No | 14. tuberculosis | ◯ Yes ◯ No |
| 15. Asthma | ◯ Yes ◯ No | 16. breathing/sleep issues (snore/sinus) | ◯ Yes ◯ No | 17. kidney disease | ◯ Yes ◯ No |
| 18. liver disease | ◯ Yes ◯ No | 19. jaundice | ◯ Yes ◯ No | 20. thyroid issues/calcium deficiency | ◯ Yes ◯ No |
| 21. hormone deficiency | ◯ Yes ◯ No | 22. high cholesterol or taking statins | ◯ Yes ◯ No | 23. diabetes | ◯ Yes ◯ No |
| 24. stomach or duodenal ulcer | ◯ Yes ◯ No | 25. digestive issues (gastric reflux) | ◯ Yes ◯ No | 26. osteoporosis/osteopenia | ◯ Yes ◯ No |
| 27. arthritis/Rhumatoid | ◯ Yes ◯ No | 28. glaucoma | ◯ Yes ◯ No | 29. head or neck injuries | ◯ Yes ◯ No |
| 30. epilepsy, convulsions (seizures) | ◯ Yes ◯ No | 31. neurologic problems (ADD, ADHD) | ◯ Yes ◯ No | 32. viral infections and cold sores | ◯ Yes ◯ No |
| 33. any lumps or swelling in mouth | ◯ Yes ◯ No | 34. hives, skin rash, hay fever | ◯ Yes ◯ No | 35. venereal disease | ◯ Yes ◯ No |
| 36. Hepatitis (List Type Below) | ◯ Yes ◯ No | 37. HIV / AIDS | ◯ Yes ◯ No | 38. tumor, abnormal growth | ◯ Yes ◯ No |
| 39. radiation therapy | ◯ Yes ◯ No | 40. chemotherapy | ◯ Yes ◯ No | 41. psychiatric treatment | ◯ Yes ◯ No |
| 42. antidepressant medication | ◯ Yes ◯ No | 43. alcohol/drug dependency | ◯ Yes ◯ No | 44. Cancer (List Type Below) | ◯ Yes ◯ No |

| | | | |
|---|---|---|---|
| Diabetes A1C Score | ☐ | If yes | |

ARE YOU:

| | | | | | |
|---|---|---|---|---|---|
| 45. being treated for any other illness | ◯ Yes ◯ No | 46. aware of change in general health | ◯ Yes ◯ No | 47. taking dietary supplements | ◯ Yes ◯ No |
| 48. often exhausted or fatigued | ◯ Yes ◯ No | 49. frequent headaches | ◯ Yes ◯ No | 50. a smoker or smoked previously | ◯ Yes ◯ No |
| 51. often unhappy or depressed | ◯ Yes ◯ No | 52. FEMALE - taking birth control pills | ◯ Yes ◯ No | 53. FEMALE - pregnant | ◯ Yes ◯ No |
| 54. MALE - prostate disorders | ◯ Yes ◯ No | 55. Vaping | ◯ Yes ◯ No | 56. Infertility Treatments | ◯ Yes ◯ No |
| 57. on meds for weight control (fen-phen | ◯ Yes ◯ No | | | | |

Current medical treatment, impending surgery, or other treatment that may affect your dental care? ◯ Yes ◯ No If yes

MEDS:

Have you taken medications, supplements, and or vitamins taken within the last two years? ◯ Yes ◯ No

Comments

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____