ENCINITAS Dental Wellness

Richard J. Gill, D.D.S.
General Family Cosmetic Dentistry

Medical History Form

Medical History

Do you have or have you ever had:

Hospitalization for illness or injury	☐YES	☐NO
An allergic reaction to		

☐ **Asprin**	☐ **Sulfa**
☐ **Ibuprofen**	☐ **Local anesthetic**
☐ **Acetaminophen**	☐ **Fluoride**
☐ **Codeine**	☐ **Metals** (nickel, gold, silver)
☐ **Penicillin**	☐ **Latex**
☐ **Erythromycin**	☐ **Other**
☐ **Tetracycline**	

Heart problems, or cardiac stent within the last six months	☐YES	☐NO
History of infective endocarditis	☐YES	☐NO
Artificial heart valve, repaired heart defect (PFO)	☐YES	☐NO
Pacemaker or implantable defibrillator	☐YES	☐NO
Artificial prothesis (heart valve or joint)	☐YES	☐NO
Rheumatic or scarlet fever	☐YES	☐NO
High or low blood pressure	☐YES	☐NO
A stroke (taking blood thinners)	☐YES	☐NO
Anemia or other blood disorder	☐YES	☐NO
Prolonged bleeding due to a slight cut (INR> 3.5)	☐YES	☐NO
Emphysema, scarcoidosis	☐YES	☐NO
Tuberculosis	☐YES	☐NO
Asthma	☐YES	☐NO
Breathing or sleep problems (I.E. snoring, sinus)	☐YES	☐NO
Kidney disease	☐YES	☐NO
Liver disease	☐YES	☐NO
Jaundice	☐YES	☐NO
Thyroid, parathyroid disease, or calcium deficiency	☐YES	☐NO
Hormone defiency	☐YES	☐NO
High Cholesterol or taking statin drugs	☐YES	☐NO
Diabetes (HbA1c=____)	☐YES	☐NO
Stomach or duodenal ulcer	☐YES	☐NO
Digestive disorders (I.E. gastic reflux)	☐YES	☐NO
Osteoporosis/ osteopenia (i.e. taking bisphosphonates)	☐YES	☐NO
Arthritis	☐YES	☐NO
Glaucoma	☐YES	☐NO
Contact lenses	☐YES	☐NO
Head or neck injuries	☐YES	☐NO
Epilepsy, convulsions (seizures)	☐YES	☐NO
Neurologic problems (attention deficit disorder)	☐YES	☐NO
Viral infections and cold sores	☐YES	☐NO
Any lumps or swelling in the mouth	☐YES	☐NO
Hives, skin rash, hay fever	☐YES	☐NO
STI/STD	☐YES	☐NO
Hepatitis	☐YES	☐NO
HIV/AIDS	☐YES	☐NO
Tumor, abnormal growth	☐YES	☐NO
Radiation therapy	☐YES	☐NO
Chemotherapy	☐YES	☐NO
Emotional problems	☐YES	☐NO
Psychiatric treatment	☐YES	☐NO
Antidepressant medication	☐YES	☐NO
Alcohol/street drug use	☐YES	☐NO

Do you have or have you ever had:

Presently being treated for any other illness	☐YES	☐NO
Aware of a change in our health (i.e. fever, new cough)	☐YES	☐NO
Taking medication for weight management (I.E. fen-phen)	☐YES	☐NO
Taking dietary supplement	☐YES	☐NO
Often exhausted or fatigued	☐YES	☐NO
Experiencing frequent headaches	☐YES	☐NO
A smoker, smoked previously or use smokeless tobacco	☐YES	☐NO
Considered a touchy person	☐YES	☐NO
Often unhappy or depressed	☐YES	☐NO
FEMALE-taking birth control pills	☐YES	☐NO
FEMALE- pregnant	☐YES	☐NO
MALE- prostate disorders	☐YES	☐NO

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possible affect your dental treatment. (I.E. Botox, Collagen Injections):

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

Please advise us in the future of any change in your medical history or any medications you may be taking.

Signature-Patient/Guardian　　　Date

Doctor Signature　　　Date

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