GENE HASSELL D.D.S.
GENERAL & COSMETIC DENTISTRY
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MEDICAL HISTORY

Name ______________ Nickname ______________ Age ______________

Name of Physician / and their specialty ______________

Most recent physical examination______________ Purpose ______________

What is your estimate on 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 six months ❑ ❑
4. History of infective endocarditis______ ❑ ❑
5. Artifical heart valve, repaired heart defect (PFO) ______ ❑ ❑
6. Pacemaker or implantable defibrillator ______ ❑ ❑
7. Artificial prosthesis (heart valve or joints)______ ❑ ❑
8. Rheumatic or scarlet fever______ ❑ ❑
9. High or low blood pressure ______ ❑ ❑
10. A stroke (taking blood thinners)______ ❑ ❑
11. Anemia or other blood disorder ______ ❑ ❑
12. Prolonged bleeding due to a slight cut (INR>3.5) ______ ❑ ❑
13. Emphysema, sarcoidosis______ ❑ ❑
14. Tuberculosis ______ ❑ ❑
15. Asthma ______ ❑ ❑
16. Breathing or sleep problems (i.e. snoring, sinus) ______ ❑ ❑
17. Kidney disease ______ ❑ ❑
18. Liver disease ______ ❑ ❑
19. Jaundice______ ❑ ❑
20. Thyroid, parathyroid desease, or calcium deficiency______ ❑ ❑
21. Hormone deficiency______ ❑ ❑
22. High cholesterol or taking statin drugs ______ ❑ ❑
23. Diabetes (HbA1c=______)______ ❑ ❑
24. Stomach or duodenal ulcer______ ❑ ❑
25. Digestive disorders (i.e. gastric reflux) ______ ❑ ❑

YES NO

26. Osteoporosis/osteopenia (i.e. taking bisphosphonates) ______ ❑ ❑
27. Arthritis______ ❑ ❑
28. Glaucoma ______ ❑ ❑
29. Contact lenses______ ❑ ❑
30. Head or neck injuries______ ❑ ❑
31. Epilepsy, convulsions (seizures) ______ ❑ ❑
32. Neurologic problems (attention deficit disorder) ______ ❑ ❑
33. Viral infections and cold sores ______ ❑ ❑
34. Any lumps or swelling in the mouth ______ ❑ ❑
35. Hives, skin rash, hay fever ______ ❑ ❑
36. STI/STD ______ ❑ ❑
37. Hepatitis (type____) ______ ❑ ❑
38. HIV/AIDS______ ❑ ❑
39. Tumor, abnormal growth ______ ❑ ❑
40. Radiation therapy ______ ❑ ❑
41. Chemotherapy______ ❑ ❑
42. Emotional problems______ ❑ ❑
43. Psychiatric treatment______ ❑ ❑
44. Antidepressant medication ______ ❑ ❑
45. Alcohol/street drug use______ ❑ ❑

ARE YOU:

46. Presently being treated for any other illness______ ❑ ❑
47. Aware of a change in your health (i.e. fever, new cough)_ ❑ ❑
48. Taking medication for weight management (i.e. fen-phen) ❑ ❑
49. Taking dietary supplements ______ ❑ ❑
50. Often exhausted or fatigued ______ ❑ ❑
51. Experiencing frequent headaches ______ ❑ ❑
52. A smoker, smoked previously or use smokeless tobacco_ ❑ ❑
53. Considered a touchy person______ ❑ ❑
54. Often unhappy or depressed ______ ❑ ❑
55. FEMALE - taking birth control pills ______ ❑ ❑
56. FEMALE - pregnant ______ ❑ ❑
57. MALE - prostate disorders ______ ❑ ❑

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possible affect your dental treatment. (i.e. Botox, Collegen Injections)

____

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

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

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 ______________