Charles Harding, DMD
Medical History

Patient Name: ____________________ Age: ________
Name of Physician & their specialty: ____________________
Most recent physical examination: ____________ Purpose: ____________

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

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ other:		
3. heart problems	☐	☐
4. heart murmur	☐	☐
5. rheumatic fever	☐	☐
6. scarlet fever	☐	☐
7. high blood pressure	☐	☐
8. low blood pressure	☐	☐
9. a stroke	☐	☐
10. artificial prosthesis (i.e. heart valve or joints)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut	☐	☐
13. emphysema	☐	☐
14. tuberculosis	☐	☐
15. asthma	☐	☐
16. sinus problems	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid or parathyroid disease	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol	☐	☐
23. diabetes	☐	☐

	YES	NO
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders	☐	☐
26. arthritis	☐	☐
27. glaucoma	☐	☐
28. contact lenses	☐	☐
29. head or neck injuries	☐	☐
30. epilepsy convulsions (seizures)	☐	☐
31. viral infections and cold sores	☐	☐
32. any lumps or swelling in the mouth	☐	☐
33. hives, skin rash, hay fever	☐	☐
34. venereal disease	☐	☐
35. hepatitis (type ____)	☐	☐
36. HIV/AIDS	☐	☐
37. tumor, abnormal growth	☐	☐
38. radiation therapy	☐	☐
39. chemotherapy	☐	☐
40. emotional problems	☐	☐
41. psychiatric treatment	☐	☐
42. antidepressant medication	☐	☐
43. alcohol/drug dependency	☐	☐
ARE YOU:		
44. presently being treated for any other illness	☐	☐
45. aware of a change in your general health	☐	☐
46. taking medication for osteoporosis/osteopenia	☐	☐
47. often exhausted or fatigued	☐	☐
48. subject to frequent headaches	☐	☐
49. a heavy smoker (1 pack or more a day)	☐	☐
50. considered a touchy person	☐	☐
51. often unhappy or depressed	☐	☐
52. easily upset or irritated	☐	☐
53. FEMALE – taking birth control pills	☐	☐
54. FEMALE – pregnant	☐	☐
55. MALE – prostate disorders	☐	☐

Describe any current treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

____

List any 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

To the best of my knowledge all the preceding answers are true and correct. If I have any change in my health or medications, I will inform Dr. Harding and his staff at my next visit. If deemed advisable, I grant permission for my physician to be contacted for further information and consultation. I further authorize the taking of diagnostic records, including dental x-rays, photographs, diagnostic casts or other diagnostic measures appropriate for a thorough evaluation. I grant permission for Dr. Harding and his staff to contact any prior dentists for transfer of any diagnostic records that may assist in my evaluation.

Patient's Signature ____________________ Date ____________

Doctor's Signature ____________________ Date ____________

MEDICAL HISTORY