Medical History

MONTREUX DENTAL CLINIC

Name of physician/and their specialty _____

Most recent physical examination _____ Purpose _____

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

DO YOU HAVE or HAVE YOU EVER HAD:	YES		YES
1. hospitalization for illness/injury _____	☐	26. hives, skin rash, hay fever	☐
2. an allergic reaction to _____	☐	27. STI / STD _____	☐
3. prolonged bleeding due to a slight cut (INR > 3.5)	☐	28. hepatitis (type _____)	☐
4. emphysema, shortness of breath	☐	29. HIV / AIDS	☐
5. tuberculosis	☐	30. tumor, abnormal growth	☐
6. asthma	☐	31. radiation therapy	☐
7. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	32. chemotherapy, immunosuppressive	☐
8. kidney disease	☐	33. emotional problems	☐
9. liver disease	☐	34. psychiatric treatment	☐
10. jaundice	☐	35. antidepressant medication	☐
11. thyroid, parathyroid disease, or calcium deficiency	☐	36. alcohol / drug addiction	☐
12. hormone deficiency	☐	37. any condition not listed above	☐
13. high cholesterol or taking statin drugs	☐	**ARE YOU:**	
14. diabetes (type 1 / 2)	☐	38. presently being treated for any other illness	☐
15. stomach or duodenal ulcer	☐	39. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐
16. digestive disorders (i.e. celiac disease, gastric reflux)	☐	40. taking medication for weight management	☐
17. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	41. taking dietary supplements	☐
18. arthritis, rheumatoid arthritis, lupus	☐	42. often exhausted or fatigued	☐
19. joint replacement (type _____)	☐	43. experiencing frequent headaches	☐
20. blood pressure (High / Low)	☐	44. a smoker, smoked previously or use smokeless tobacco (amount per day _____, used for _____ months / years)	☐
21. head or neck injuries	☐	45. considered a touchy person	☐
22. epilepsy, convulsions (seizures)	☐	46. often unhappy or depressed	☐
23. neurologic disorders (ADD/ADHD, prion disease)	☐	47. FEMALE - taking birth control pills	☐
24. viral infections and cold sores	☐	48. FEMALE - pregnant	☐
25. any lumps or swelling in the mouth	☐	49. MALE - experiencing prostate disorders	☐

Additional Comments: _____

_____

List all medications, supplements, and vitamins that you are taking or have 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/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____