GREGSON & ASSOCIATES DENTISTRY

MEDICAL HISTORY

JEFFREY GREGSON, DDS

INFORMATION

Name (Full) _____ Birthdate _____

FIRST NAME / MIDDLE INITIAL / LAST NAME — MM / DD / YYYY

PREVIOUS PHYSICIAN AND/OR SPECIALTY PHYSICIAN

NAME OF PHYSICIAN/AND THEIR SPECIALTY _____

MOST RECENT PHYSICAL EXAMINATION? _____ PURPOSE? _____

WHAT IS YOUR ESTIMATE OF YOUR GENERAL HEALTH? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

PERSONAL HISTORY / DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO
1. Hospitalization for Illness or Injury	☐	☐
2. An Allergic or Bad Reaction to Any of the Following:		
☐ aspirin, ibuprofen, acetaminophen, codeine.		
☐ penicillin.		
☐ sulfa.		
☐ local anesthetic.		
☐ fluoride.		
☐ chlorhexidine (Chx).		
☐ metals (nickel, gold, silver, _____).		
☐ latex.		
☐ red dye.		
☐ other _____.		
3. Heart Problems or Cardiac Stent within the Last Six Months	☐	☐
4. History or Infective Endocarditis	☐	☐
5. Artificial Heart Valve, Repaired Heart Defect (PFO)	☐	☐
6. Pacemaker or Implantable Defibrillator	☐	☐
7. Orthopedic or Soft Tissue Implant (e.g. Joint Replacement, Breast Implant)	☐	☐
8. Heart Murmur	☐	☐
9. High Blood Pressure	☐	☐
10. A Stroke (Taking Blood Thinners)	☐	☐
11. Anemia or Other Blood Disorder	☐	☐
12. Prolonged Bleeding Due to a Slight Cut (or Inr > 3.5)	☐	☐
13. Pneumonia, Emphysema, Shortness Of Breath, Sarcoidosis	☐	☐
14. Chronic Ear Infections, Tuberculosis	☐	☐
15. Breathing Problems (e.g. Asthma, Nasal Breathing, Stuffy Nose, Sinus Congestion)	☐	☐
16. Sleep Problems (e.g. Sleep Apnea, Snoring, Insomnia, Restless Sleep, Bedwetting)	☐	☐
17. Kidney Disease	☐	☐
18. Liver Disease or Jaundice	☐	☐
19. Vertigo (e.g. "The Room Is Spinning")	☐	☐
20. Thyroid, Parathyroid Disease, or Calcium Deficiency	☐	☐
21. High Cholesterol or Taking Statin Drugs	☐	☐
22. Diabetes (Hba1c=	☐	☐
23. Stomach or Duodenal Ulcer	☐	☐

	YES	NO
24. Digestive or Eating Disorders (e.g. Gastric Reflux, Bulimia, Anorexia, Celiac Disease, Crohn's Disease, or any Inflammatory Bowel Disease)	☐	☐
25. Osteoporosis/Osteopenia or ever taken an Anti-Resorptive Medications (e.g. Bisphosphonates)	☐	☐
26. Arthritis or Gout	☐	☐
27. Autoimmune disease (e.g. Rheumatoid Arthritis, Lupus, Scleroderma)	☐	☐
28. Head or Neck Injuries	☐	☐
29. Epilepsy, Convulsions (Seizures)	☐	☐
30. Neurologic Disorders (e.g. Alzheimer's Disease, Dementia, Prion Disease)	☐	☐
31. Viral Infections (e.g. Cold Sores) bacterial Infection (e.g. Lyme disease)	☐	☐
32. Any Lumps or Swelling in the Mouth	☐	☐
33. Hives, Skin Rash, Hay Fever	☐	☐
34. STD/HPV	☐	☐
35. Hepatitis (type _____)	☐	☐
36. HIV/AIDS	☐	☐
37. Tumor, Abnormal Growth	☐	☐
38. Radiation Therapy	☐	☐
39. Chemotherapy, Immunosuppressive Medication	☐	☐
40. Difficulties with Stress Management	☐	☐
41. Psychiatric Treatment, Antidepressants, Mood Stabilizing Medications	☐	☐
42. Concentration Problems or ADD/ADHD	☐	☐
43. Recreational drug use	☐	☐
ARE YOU:		
44. Presently Being Treated for any other illness	☐	☐
45. Taking Medication For Weight Management	☐	☐
46. Taking Dietary Supplements, Vitamins, and/or Probiotics	☐	☐
47. Often Exhausted or Fatigued	☐	☐
48. Experiencing Frequent Headaches or Chronic Pain	☐	☐
49. A Smoker, Smoked Previously or Other (e.g. Smokeless Tobacco, Vaping, E-Cigarettes, And Cannabis)	☐	☐
50. Considered A Touchy/Sensitive Person	☐	☐
51. Often Unhappy or Depressed	☐	☐
52. Currently Pregnant	☐	☐

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

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

Drug _____ Purpose _____ Drug _____ Purpose _____

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 Signature _____ Date _____

ASA _____ (1-6)

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