WELLNESS BIODENTISTRY

MEDICAL HISTORY

Please select if you are taking any of the following:

☐ Alcohol ☐ Chewing tobacco ☐ Smoking ☐ Aspirin ☐ Herbal supplements ☐ Vitamins

List any prescription medication you are currently taking:_____

_____

_____

_____

Are you currently under the care of a physician or naturopath? ☐ YES ☐ NO

If yes, what are you being treated for? _____

_____

List any surgeries or hospitalizations: _____

_____

Has your cardiologist or orthopedist recommended antibiotics before dental treatment? ☐ YES ☐ NO

Are you pregnant or nursing? ☐ YES ☐ NO

Has anyone in your family suffered from the following? (Select all that apply)

☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Cancer (type?) _____

Do you have allergies to any of the following?

☐ Acrylic ☐ Food Allergies ☐ Latex ☐ Jewelry/metals ☐ Anesthetics ☐ Penicillin

Do you have or have you ever had any of the following?

☐ Arthritis ☐ Artificial joint ☐ Asthma ☐ Back/neck problems

☐ Blood thinners ☐ Cancer (type?)_____ ☐ Celiac ☐ Depression ☐ Diabetes

☐ Dizziness ☐ Emphysema ☐ Epilepsy/seizures ☐ Excessive bleeding

☐ Frequent headaches ☐ Frequent heartburn ☐ Heart disease ☐ Heart murmur ☐ Hepatitis

☐ High blood pressure ☐ HIV/AIDS ☐ Kidney problems ☐ Liver disease

☐ Memory problems ☐ MTHFR gene mutation ☐ Nervousness ☐ Pacemaker

☐ Pregnant (current) Due_____ ☐ Psychiatric disorder ☐ Seasonal allergies

☐ Sleep disorder ☐ Stroke ☐ Ulcers ☐ Vision loss

Is there any other medical condition that we need to be aware of? _____

_____

Signature: _____Relationship to patient_____Date_____