FLAGSHIP DENTAL

DR. TURTON & ASSOCIATES

MEDICAL HISTORY

Name | Name of Physician/and their specialty | Most recent physical examination

Preferred Name | Purpose

Date of Birth | What is your estimate of 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 or bad reaction to any of the following:	☐	☐
	☐ aspirin, ibuprofen, acetaminophen, codeine		
	☐ penicillin		
	☐ erythromycin		
	☐ tetracycline		
	☐ sulfa		
	☐ local anesthetic		
	☐ fluoride		
	☐ chlorhexidine (CHX)		
	☐ metals (nickel, gold, silver,)		
	☐ latex		
	☐ nuts		
	☐ fruit		
	☐ other		
3.	heart problems, or cardiac stent within the last six months	☐	☐
4.	history of infective endocarditis	☐	☐
5.	artificial heart valve, repaired heart defect (PFO)	☐	☐
6.	pacemaker or implantable defibrillator	☐	☐
7.	orthopedic implant (joint replacement)	☐	☐
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.	pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15.	asthma	☐	☐
16.	breathing or sleep problems (e.g., sleep apnea, snoring, sinus)	☐	☐
17.	kidney disease	☐	☐
18.	liver disease	☐	☐
19.	jaundice	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency	☐	☐
21.	hormone deficiency	☐	☐
22.	high cholesterol or taking statin drugs	☐	☐
23.	diabetes (HbA1c =)	☐	☐
24.	stomach or duodenal ulcer	☐	☐
25.	digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26.	osteoporosis/osteopenia (e.g., taking bisphosphonates)	☐	☐
27.	arthritis	☐	☐
28.	autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	glaucoma	☐	☐
30.	contact lenses	☐	☐
31.	head or neck injuries	☐	☐
32.	epilepsy, convulsions (seizures)	☐	☐
33.	neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34.	viral infections and cold sores	☐	☐
35.	any lumps or swelling in the mouth	☐	☐
36.	hives, skin rash, hay fever	☐	☐
37.	STI/STD/HPV	☐	☐
38.	hepatitis (type)	☐	☐
39.	HIV/AIDS	☐	☐
40.	tumor, abnormal growth	☐	☐
41.	radiation therapy	☐	☐
42.	chemotherapy, immunosuppressive medication	☐	☐
43.	emotional difficulties	☐	☐
44.	psychiatric treatment	☐	☐
45.	antidepressant medication	☐	☐
46.	alcohol/recreational drug use	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness	☐	☐
48.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	☐	☐
49.	taking medication for weight management	☐	☐
50.	taking dietary supplements	☐	☐
51.	often exhausted or fatigued	☐	☐
52.	experiencing frequent headaches	☐	☐
53.	a smoker, smoked previously or use smokeless tobacco	☐	☐
54.	considered a touchy/sensitive person	☐	☐
55.	often unhappy or depressed	☐	☐
56.	taking birth control pills	☐	☐
57.	currently pregnant	☐	☐
58.	diagnosed with a prostate disorder	☐	☐

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, and or vitamins taken within the last two years

DATE | PATIENT'S SIGNATURE

DATE | DOCTOR'S SIGNATURE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

ASA