KEVIN SORGE, DDS
EXCELLENCE IN DENTISTRY

Medical History

Patient Name:____Nickname:______________________Age:__________

Name of physician and their specialty:____

Most recent physical exam:_____________________________Purpose:_______________________________________

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 reaction to ◯ aspirin, ibuprofen, acetaminophen, codeine ◯ penicillin ◯ erythromycin ◯ tetracycline ◯ sulfa ◯ local anesthetic ◯ fluoride ◯ metals (nickel, gold, silver,____________) ◯ latex ◯ other:________________		
3. Heart problems or cardiac stent with the last 6 months	◯	◯
4. History of infective endocarditis	◯	◯
5. Artificial heart valve or repaired hear defect (PFO)	◯	◯
6. Pacemaker if implantable defibrillator	◯	◯
7. Artificial prosthesis (heart valve or joints)	◯	◯
8. Orthopedic implant (joint replacement)	◯	◯
9. Rheumatic or scarlet fever	◯	◯
10. High or low blood pressure	◯	◯
11. A stroke (taking blood thinners)	◯	◯
12. Anemia or other blood disorder	◯	◯
13. Prolonged bleeding due to slight cut (INR > 3.5)	◯	◯
14. Emphysema, shortness of breath, Sarcoidosis	◯	◯
15. Tuberculosis, measles, chicken pox	◯	◯
16. Asthma	◯	◯
17. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	◯	◯
18. Kidney disease	◯	◯
19. Liver disease	◯	◯
20. Jaundice	◯	◯
21. Thyroid, parathyroid disease or calcium deficiency	◯	◯
22. Hormone deficiency	◯	◯
23. High cholesterol or taking statin drugs	◯	◯
24. Diabetes (HbA1c=______)	◯	◯
25. Stomach or duodenal ulcer	◯	◯
26. Digestive disorders (i.e. celiac disease, gastric reflux)	◯	◯
27. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	◯	◯

	YES	**NO**
28. Arthritis	◯	◯
29. Autoimmune disease (ie rheumatoid arthritis, lupus, scleroderma)	◯	◯
30. Glaucoma	◯	◯
31. Contact lenses	◯	◯
32. Head or neck injuries	◯	◯
33. Epilepsy, convulsions (seizures)	◯	◯
34. Neurologic disorders (ASS/ADHD, prion disease)	◯	◯
35. Viral infections or cold sores	◯	◯
36. Any lumps or swelling in mouth	◯	◯
37. Hives, skin rash, hay fever	◯	◯
38. STI/STD/HPV	◯	◯
39. Hepatitis (type ________)	◯	◯
40. HIV/AIDS	◯	◯
41. Tumor, abnormal growth	◯	◯
42. Radiation therapy	◯	◯
43. Chemotherapy, immunosuppressive meds	◯	◯
44. Emotional difficulties	◯	◯
45. Psychiatric treatment	◯	◯
46. Antidepressant medication	◯	◯
47. Alcohol/recreational drug use	◯	◯
ARE YOU:		
48. Presently being treated for any other illness	◯	◯
49. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough or diarrhea)	◯	◯
50. Taking medication for weight management (i.e. fen-phen)	◯	◯
51. Taking dietary supplements	◯	◯
52. Often exhausted or fatigued	◯	◯
53. Experiencing frequent headaches	◯	◯
54. A smoker, smoked previously or use smokeless tobacco	◯	◯
55. Considered a touchy person/sensitive	◯	◯
56. Often unhappy or depressed	◯	◯
57. **FEMALE:** Taking birth control pills	◯	◯
58. **FEMALE:** Pregnant	◯	◯
59. **MALE:** Prostate disorders	◯	◯

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

____

List all medications, supplements and/or vitamins taken within the last 2 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 Signature:____Date:________________

Doctor's Signature:____Date:________________

ASA__________(1-6) | ◯ | ◯ | ◯ |