# SYSTEMIC INFLAMMATORY MEDICAL HISTORY

**PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY:**

Yes___ No ___ COPD
Yes ___ No ___ Diabetes
Yes ___ No ___ Heart Attack
Yes ___ No ___ High Carb Diet
Yes ___ No ___ High Stress
Yes ___ No ___ Hypertension/High Blood Pressure
Yes ___ No ___ Lack of Exercise
Yes ___ No ___ Osteoporosis
Yes ___ No ___ Past Miscarriage
Yes ___ No ___ Periodontal Disease
Yes ___ No ___ Planning a Family
Yes ___ No ___ Poor Sleep Quality
Yes ___ No ___ Pregnant Now
Yes ___ No ___ Rheumatoid Arthritis
Yes ___ No ___ Smoker (past 3 years)
Yes ___ No ___ Stroke / TIA
Yes ___ No ___ GI Disorders/IBS/Crohn's

**PLEASE INDICATE IF ANY FAMILY HISTORY APPLIES:**

Has a parent or grandparent had heart disease, heart attack, or stroke? Yes ___ No ___
Has a parent or grandparent had diabetes? Yes ___ No ___
Has a parent or grandparent had periodontal disease? Yes ___ No ___
Has a parent or grandparent had COPD? Yes ___ No ___
Has a parent or grandparent had cancer? Yes ___ No ___

**GENERAL MEDICAL HISTORY:**

Yes ___ No ___ ADD/ADHD
Yes ___ No ___ AIDS or HIV+
Yes ___ No ___ Alcohol Dependency
Yes ___ No ___ Allergies
Yes ___ No ___ Alzheimer's
Yes ___ No ___ Anemia
Yes ___ No ___ Arthritis
Yes ___ No ___ Artificial Heart Valve
Yes ___ No ___ Asthma
Yes ___ No ___ Birth Control Meds
Yes ___ No ___ Blood Disorders
Yes ___ No ___ Congenital Heart Valve
Yes ___ No ___ Drug Dependency
Yes ___ No ___ Dry Mouth
Yes ___ No ___ Earaches
Yes ___ No ___ Emotional Concerns
Yes ___ No ___ Endocarditis
Yes ___ No ___ Epilepsy
Yes ___ No ___ Fainting Spells
Yes ___ No ___ GERD
Yes ___ No ___ Glaucoma
Yes ___ No ___ Headaches
Yes ___ No ___ Heart Angina
Yes ___ No ___ Heart Murmur
Yes ___ No ___ Herpes [oral]
Yes ___ No ___ Jaw Clicks/noise
Yes ___ No ___ Kidney Disease
Yes ___ No ___ Liver Disease
Yes ___ No ___ Low Blood Pressure
Yes ___ No ___ Lung Disease
Yes ___ No ___ Cancer [Type _____]
Yes ___ No ___ Heart Surgery [Date _____]
Yes ___ No ___ Hepatitis [Type _____]
Yes ___ No ___ Mitral Valve Prolapse
Yes ___ No ___ Pacemaker
Yes ___ No ___ Prosthetic Joint
Yes ___ No ___ Psychiatric Care
Yes ___ No ___ Radiation Therapy
Yes ___ No ___ Rheumatic Fever
Yes ___ No ___ Sleep Apnea
Yes ___ No ___ Thyroid Disorder
Yes ___ No ___ Tonsils Removed
Yes ___ No ___ Tuberculosis
Yes ___ No ___ Ulcers
Yes ___ No ___ Wear a CPAP -- Every night: Yes ___ No ___

Other _____

**ALLERGY REPORT:**

Yes ___ No ___ Allergic to Antibiotics / List: _____
Yes ___ No ___ Allergic to Metals. List if so: _____
Yes ___ No ___ Allergic to Latex
Yes ___ No ___ Allergic to other Medications / List: _____
_____

**GENERAL HEALTH:**

Yes ___ No ___ Are you in good general health now?
Yes ___ No ___ Do you feel well?
Yes ___ No ___ Are you under the regular care of a physician at this time?
Date of last physical: _____
Reason for regular medical care, if required: _____
Name of MD: _____ Phone number: _____
Have you had a serious illness, been hospitalized? Explain briefly _____
Have you had chemo or radiation therapy for cancer? How long ago? _____
Yes ___ No ___ Have you used tobacco products in the past.
Yes ___ No ___ Currently Nursing or Pregnant.
Yes ___ No ___Have you had a joint replacement in the past two years.

- **Yes ___ No ___Been advised by MD to take antibiotics before dental appointment.**
- **Please provide a list of current medications**

**Other important medical considerations: _____**

I consent to dental and oral surgical procedures "agreed upon". I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing you of any changes to my health at my next appointment.

Signature of Patient/Parent: _____ Date _____ Signature of Dentist _____