

MEDICAL HISTORY FOR: _____

What is your estimation of your general health? GOOD _____ FAIR _____ POOR _____
Height _____ Weight _____

Yes No Are you now under the regular care of a physician? If so, for what? _____

Yes No Have you had any major operations, hospitalizations, or illnesses? If yes, for what and when?

Yes No Do you smoke? If yes . . . for how long, and how much? _____

Please list all medications or drugs (prescription and over-the-counter) you are taking:

Have you ever had a reaction to any of the following: (PLEASE CIRCLE 'Y' for yes and 'N' for no)

- | | | |
|-----------------|--|-----------------|
| Y N Penicillin | Y N Sleeping pills (valium halcion, . . .) | Y N Ibuprofen |
| Y N Sulfa drugs | Y N Tetracycline/Doxycycline | Y N Clindamycin |
| Y N Codeine | Y N Dental Anesthetic | Y N Vicodin |
| Y N Aspirin | Y N Nitrous Oxide | Y N Latex |

Others: _____

Have you ever had to **premedicate** with antibiotics for dental procedures? Y N

Do you have or have you ever had: (PLEASE CIRCLE 'Y' for yes and 'N' for no):

- | | |
|---|--|
| Y N Heart murmur | Y N Ulcers (Stomach or Duodenum) |
| Y N Mitral Valve Prolapse | Y N Kidney or bladder trouble |
| Y N Rheumatic fever | Y N Stroke / Heart Attack |
| Y N Diabetes (Sugar Disease) | Y N Thyroid or parathyroid disease |
| Y N Abnormal thirst | Y N Asthma or difficulty breathing |
| Y N High or Low blood pressure | Y N Frequent vomiting or diarrhea |
| Y N Angina Pectoris | Y N Arthritis / Rheumatism |
| Y N Problems in healing | Y N Artificial joints, valves, hip replacement |
| Y N Blood transfusion / Bleeding problems | Y N Dizziness or light headedness |
| Y N Frequent headaches | Y N Rashes or skin disorders |
| Y N Hepatitis, jaundice, or other liver disease | Y N Epilepsy, seizures, convulsions, or fainting |
| Y N Swelling of the hands, feet, or eyes | Y N Shortness of breath or chest pains |
| Y N Frequent fractures or dislocations | Y N Painful or frequent urination |
| Y N Condition requiring cortisone or other steroids | Y N Glaucoma |
| Y N Allergies or Sinus Problems | Y N HIV Positive / AIDS |
| Y N Tuberculosis | Y N X-ray or radiation treatment |
| Y N Pacemaker | Y N Taken the diet drug Phen Phen |
| Y N Chemotherapy (Cancer, Leukemia) | Y N Taken bisphosphorous (e.g. Actonel, Boneva, Fosamax) |
| Y N Tumors or growth | |

DENTAL HISTORY

Yes No Have you had any serious trouble associated with any previous dental treatment? If yes, explain _____

Yes No Do you have bleeding gums? _____

Yes No Have you ever had periodontal (gum) treatment? _____

Yes No Are you missing teeth? If so, why? _____

Yes No Are you committed and willing to become actively involved in the treatment of your periodontal disease?

What is your chief complaint concerning your mouth or teeth? _____

FOR WOMEN ONLY

Yes No Are you pregnant? _____

Yes No Are you taking birth control pills? If so, what? _____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES I WILL INFORM THE OFFICE IMMEDIATELY.

Patient's Signature Date

Doctor's Signature Hygienist's Signature