Woodyard Periodontics

MEDICAL HISTORY

Patient Name ____

Date of Birth_________ Age_______Sex_____Height_______ Weight_______

FOR OFFICE USE	
ASA class	
Initial Vital Signs	
BP	
Pulse	

Please circle your answer to the following questions. Your answers are for our records only and will be considered confidential.

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. Yes No Has there been any change in your health within the last year?
2. Yes No Have you been hospitalized or had any serious illnesses in the past 5 years?
   If yes, please explain____
3. Yes No Are you currently being treated for any illnesses?
   If yes, what conditions? ____
   Date of last medical exam___________
4. Yes No Have you had surgery or x-ray treatment for any condition of your mouth or lips?
5. Yes No Have you had any problems with prior dental treatment?
6. Yes No Have you ever had to take antibiotics prior to seeing the dentist?
   What is the name and address of your physician? ________________________
   ____
   ____

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Difficulty swallowing?
14. Yes No Sinus problems?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Dry mouth?
26. Yes No Jaundice?
27. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

28. Yes No Heart disease?
29. Yes No Heart attack, heart defects?
30. Yes No Heart murmurs?
31. Yes No Rheumatic fever?
32. Yes No Stroke, hardening of arteries?
33. Yes No High blood pressure?
34. Yes No Low blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Family history of diabetes, heart problems, tumors?
39. Yes No HIV+ or AIDS

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IV. DO YOU HAVE OR HAVE YOU HAD:

40. Yes No Tumors, cancer?
41. Yes No Arthritis, rheumatism?
42. Yes No Hives, skin rash?
43. Yes No Anemia, blood disease?
44. Yes No VD (syphilis or gonorrhea)?
45. Yes No Herpes?
46. Yes No Kidney, bladder disease?
47. Yes No Thyroid, adrenal disease?
48. Yes No Diabetes?
49. Yes No Psychiatric care?
50. Yes No Non-Dental exposure to radiation or x-rays?
51. Yes No Chemotherapy?
52. Yes No Prosthetic heart valve?
53. Yes No Artificial joint?
54. Yes No Hospitalization?
55. Yes No Blood transfusions?
56. Yes No Surgeries?
57. Yes No Pacemaker?
58. Yes No Adverse reactions to medications? ***(If yes, please list on following page)***
59. Yes No Allergies (Drug, Latex, etc?) ***(If yes, please list on following page)***

V. ARE YOU TAKING:

60. Yes No Recreational drugs?
61. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
62. Yes No Tobacco in any form? ***(If yes, what type? Cigarette__ Pipe/cigar__ Smokeless__***
    <u>If cigarettes</u>, how many packs per day? _____ For how many years? _____
    <u>If yes</u>, would you be interested in methods to help you quit? Y N
63. Yes No Alcohol? ***(If yes, how many drinks (8 oz.) per week? ___ For how many years? ___)***
64. Yes No Prescription drugs? ***(If yes, please list on following page)***
65. Yes No Nonprescription drugs? ***(If yes, please list on following page)***
66. Yes No Ginger, Garlic, Ginko Biloba, or Ginseng? ***(If yes, please list on following page)***
67. Yes No Medications for bone loss such as **Fosamax, Actonel, Boniva, Zometa, or Aredia** in the past **3 years**? ***(If yes, please list on following page)***

VI. WOMEN ONLY:

68. Yes No Are you or could you be pregnant or nursing?
69. Yes No Are you taking birth control pills or fertility drugs?
70. Yes No Do you have problems associated with your menstrual period?

VII. ALL PATIENTS:

71. Yes No Do you have or have you had any other diseases or medical problems not listed above?
    If yes, please explain____

To the best of my knowledge, I have answered every question completely and accurately. I understand that this information will be help in the strictest confidence and it is <u>my responsibility</u> to inform this office of any changes in my medical status.

Patient's signature:____Date:____________________

RECALL REVIEW: (yearly)

1. Patient's signature____ Date:____________ BP ___/___ Pulse ___

2. Patient's signature____ Date:____________ BP ___/___ Pulse ___

3. Patient's signature____ Date:____________ BP ___/___ Pulse ___

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MEDICATIONS

Please list all your medications (IV, prescription, OTC, Herbal, etc.)

Patient Name____Date_________

Name of Drug	*Purpose / Medical Condition*	*Strength / Dosage*	*How many times per day?*

ALLERGIES/ ADVERSE REACTIONS

What causes the allergy or adverse reaction?	*Your reaction*