NAPERVILLE PERIODONTICS **JOHN P. McNAMARA DDS, MS**

PATIENT INFORMATION

Patient's name______________________________________ Date of birth______________
Street____
City______________________________ State________ Zip Code_____________________
Telephone: Home____________________ Cell__________________ Work________________
Email address____
Referred by____

MEDICAL HISTORY

Name and location of primary **medical physician**___________________________________
Medical physician phone number____
Are you currently being treated for any medical condition? Yes No
If "yes" what is the condition____
Are you currently taking any medications including aspirin or birth control pills Yes No
If "yes" what medications____
____

Circle any of the following you have had or now have.

Heart disease	High Blood Pressure	Heart Murmur	Stroke
Mitral valve prolapse	Artificial joint	Diabetes	Cancer
Epilepsy or seizures	Bleeding disorder	Arthritis	Asthma
Liver problem/hepatitis	Respiratory problem	Sinus problem	Fainting
Kidney problem	Stomach problem	HIV infection	Tuberculosis
Depression or anxiety	Psychiatric illness	Osteoporosis	GERD

Are you pregnant? Yes No
Do you smoke? Yes No If "yes" how much per day_________ How many years______
Are you allergic to any medications? Yes No
If "yes" please indicate the medications____
Circle any medications you may have problems taking: Dental anesthetics Amoxicillin
Penicillin Tetracycline Clindamycin Aspirin Ibuprofen Tylenol Codeine Vicodin

Other medical conditions or concerns not listed above___________________________________
____
Indicate any surgery or hospitalizations in the past five years______________________________
____

DENTAL INFORMATION

Are you having dental pain Yes No
Do your gums bleed or swell Yes No
Have you ever had periodontal (gum) treatment Yes No
How often do you brush your teeth ____
How often do you use dental floss ____
How often do you have your teeth cleaned____

Signature____ Date_____________