

PATIENT MEDICAL DENTAL HISTORY

1. Are you having pain or discomfort at this time?..... YES NO
2. Have you ever been hospitalized? YES NO
Please list most recent surgeries _____

3. Have you been a recipient of any artificial organs, joints or valves?..... YES NO
4. Have you been under the care of a medical doctor during the past two years? YES NO
Physician's Name _____
Address _____ Telephone _____
5. Have you taken any medication or drugs during the past two years? YES NO
6. Are you now taking any medication? If so, please list _____ YES NO

7. Are you aware of being allergic to or have you ever reacted adversely to any medication?..... YES NO
8. Please indicate by check which of the following you have had or have at present.....

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|--|---|---|--|
| Heart Failure Heart Disease or Attack Angina Pectoris Congenital Heart Disease Heart Murmur High Blood Pressure Arteriosclerosis Mitral Valve Prolapse Artificial Heart Valve Heart Pacemaker Heart Surgery Rheumatic Fever Arthritis | Stroke Artificial Joints Kidney Trouble Ulcers Diabetes Thyroid Problems Glaucoma Cosmetic Surgery Emphysema Chronic Cough Tuberculosis Asthma Hay Fever | Hepatitis A (infectious) Hepatitis B (serum) Venereal Disease A.I.D.S. H.I.V. Positive Cold Sores/Fever Blisters Blood Transfusion Hemophilia Anemia Sickle Cell Disease Bruise Easily Liver Disease Yellow Jaundice | Rheumatism Pain in Jaw Joints Cortisone Medicine Drug Addiction Allergies or Hives Sinus Trouble Radiation Therapy Chemotherapy Epilepsy or Seizures Fainting or Dizzy Spells Nervousness Psychiatric Treatment |
|--|---|---|--|

9. Do you smoke?..... YES NO
How many years? _____ Pack per day _____
10. Do you drink alcoholic beverages? YES NO
Average drinks per week _____
11. Do you experience pain in your chest, shortness of breath, or feel very tired? YES NO
12. Do your ankles swell during the day?..... YES NO
13. ..Have you lost or gained more than 10 pounds in the past year?..... YES NO
14. Has your medical doctor ever said you have cancer or a tumor?..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? YES NO
If yes, please list: _____
16. Has your physician ever recommended that you be premedicated with antibiotics before any dental treatment?..... YES NO

FOR WOMEN ONLY:

Are you pregnant? YES, what month? _____ NO Are you nursing? YES NO
Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with periodontal care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Please Print Name _____