

Patient Name _____

MEDICAL HISTORY



Medical Alert _____ **BP** _____

1. Have you been under the care of a Medical Doctor during the past 2 years? _____ Yes No

If Yes, for what? _____

Physician's Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

2. Have you ever taken any medication or drugs during the past 2 years? _____ Yes No

3. Are you taking any medications, drugs or pills now? (i.e. Aspirin) _____ Yes No

If Yes, please list name and dosage _____

4. Have you ever had an allergic or adverse reaction to any medication or substance? _____ Yes No

If Yes, please list: _____

5. Have you been a patient in a hospital during the past 5 years? _____ Yes No

6. Indicate which of the following you have had, or have at present. Circle Yes or No to each item.

Heart (Surgery, Disease, Attack) _____	Yes	No	Glaucoma _____	Yes	No	Hepatitis A, B or C _____	Yes	No
Chest pain _____	Yes	No	Contact Lenses _____	Yes	No	Venereal Disease _____	Yes	No
Congenital Heart Disease _____	Yes	No	Emphysema _____	Yes	No	A.I.D.S. _____	Yes	No
High Blood Pressure _____	Yes	No	Chronic Cough _____	Yes	No	H.I.V. Positive _____	Yes	No
Artificial Heart Valve _____	Yes	No	Tuberculosis _____	Yes	No	Sickle Cell Disease _____	Yes	No
Heart pacemaker _____	Yes	No	Asthma _____	Yes	No	Bruise Easily _____	Yes	No
Arthritis/ Rheumatism _____	Yes	No	Hay Fever _____	Yes	No	Liver Disease _____	Yes	No
Cortisone Medicine _____	Yes	No	Latex Sensitivity _____	Yes	No	Yellow Jaundice _____	Yes	No
Swollen Ankles _____	Yes	No	Allergies or Hives _____	Yes	No	Neurological Disorders _____	Yes	No
Stroke _____	Yes	No	Sinus Trouble _____	Yes	No	Epilepsy or Seizures _____	Yes	No
Diet (Special/Restricted) _____	Yes	No	Radiation Therapy _____	Yes	No	Fainting or Dizzy Spells _____	Yes	No
Artificial Joints (hip, knee, etc) _____	Yes	No	Chemotherapy _____	Yes	No	Nervous/ Anxious _____	Yes	No
Kidney Trouble _____	Yes	No	Tumor _____	Yes	No	Psychiatric/Psychological Care _____	Yes	No
Ulcers _____	Yes	No	Cold Sores/Fever Blisters _____	Yes	No			
Diabetes _____	Yes	No	Blood Transfusion _____	Yes	No			
Thyroid Problems _____	Yes	No	Hemophilia _____	Yes	No			

7. Do you use more than 2 pillows to sleep? _____ Yes No

8. Have you lost or gained more than 10 pounds in the past year? _____ Yes No

9. Do you have or have you had any disease, condition, or problem not listed above? _____ Yes No

If yes, please list _____

10. **Women.** Are you **pregnant?** Yes ___ Months. No **Nursing?** Yes No **Taking Birth Control Pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the periodontist of any change in my health or medications.

Signature of Patient, Parent or Guardian **Date**

Signature of Periodontist **Date**

Doctor's Comments: _____
