the periodontal group

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Practice Limited to Periodontics

Medical History

Date: _____

Name: _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Yes/No Are you in good health?

Yes/No Has there been any change in your general health in the last year?

Yes/No My last physical examination was on ?

Yes/No Are you now under the care of a physician?
If so, what is the condition being treated?
The name and address of my physician is
The name of the person to notify in case of an emergency.
Phone number

Yes/No Have you had any serious illness or operation?
If so what was the illness or operation?

Yes/No Have you been hospitalized or had a serious illness within the last five (5) years?
If so, what was the problem?

Do you have or have you any of the following diseases or problems?

Yes/No Damaged heart valves or artificial heart valves, including heart murmur.
Yes/No Mitral valve prolapsed
Yes/No Congenital heart lesions
Yes/No Cardiovascular disease (heart trouble, heart attack coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, rheumatic heart disease)
Yes/No Do you have pain in chest upon exertion?
Yes/No Are you ever short breathed after mild exercise?
Yes/No Do your ankles swell?
Yes/No Do you get short of breathe when you lie down, or do you require extra pillows when you sleep?
Yes/No Do you have a cardiac pacemaker?
Yes/No Do you have sinus trouble?
Yes/No Asthma or hay fever?

Yes/No Hives or Skin rash?
Yes/No Fainting spells or seizures?
Yes/No Diabetes?
Yes/No Do you have to urinate (pass water) more than 6 times a day?
Yes/No Are you thirsty much of the time?
Yes/No Does your mouth frequently become dry?
Yes/No Hepatitis, jaundice, or liver disease?
Yes/No Arthritis?
Yes/No Inflammatory rheumatism (painful swollen joints)?
Yes/No Stomach Ulcers?
Yes/No Kidney trouble?
Yes/No Tuberculosis?
Yes/No Do you have a persistent cough or cough up blood?
Yes/No Low blood pressure?
Yes/No Venereal disease?
Yes/No Epilepsy?
Yes/No Psychiatric problems?
Yes/No Cancer?
Yes/No AIDS or other immunosuppressive disorders?
Yes/No Artificial joints, prosthetic hip, etc?
Yes/No Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
Yes/No Do you bruise early?
Yes/No Have you ever required a blood transfusion?
If so , explain the circumstances?
Yes/No Do you have any blood disorder such as anemia?
Yes/No Have you had surgery,x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?

Are you taking any drug or medicine?

Yes/No Antibiotics or sulfa drugs?
Yes/No Anticoagulants (blood thinners)?
Yes/No Medicine for high blood pressure?
Yes/No Cortisone (steroids)?
Yes/No Tranquilizers?
Yes/No Antihistamines?
Yes/No Aspirin?
Yes/No Insulin, tolbutamide, (Orinase) or similar drug?
Yes/No Digitalis or drugs for heart trouble?
Yes/No Nitroglycerine?
Yes/No Oral Contraceptive or other hormonal therapy?
Other?

_____

_____

Are you allergic or have you reacted adversely to:

Yes/No Local Anesthetics?
Yes/No Penicillin or other antibiotics?
Yes/No Sulfa drugs?
Yes/No Barbiturates, sedatives, or sleeping pills?
Yes/No Aspirin?
Yes/No Iodine?
Yes/No Codeine or other Narcotics?
Other?
Yes/No Have you had any serious trouble associated with any previous dental treatment?
If so, explain.
Yes/No Do you have any disease, condition or problem not listed above that you think I should know about? If so, explain
Yes/No Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation
Yes/No Are you wearing contact lenses?
Yes/No Have you had anything to eat or drink in the last 4 hours?
Yes/No Are you wearing removable dental appliances?
Yes/No Do you smoke?
How much?
How long?

Women
Yes/No Do you have any problem associated with your menstrual period?
Yes/No Are you pregnant?
Yes/No Are you nursing?

I certify that I have read and understand the above. I acknowledge that my questions, if any about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature

_____
Signature