PERIODONTAL SURGICAL ARTS

Medical History Form

YOUR NAME _____ _____ Birth Date _____

Although our periodontal specialty focuses on oral medicine, your oral cavity is part of your overall health. Any health problems you have or medications that you may be taking can have important interrelationship with your dental care. Thank you for answering the following questions. Your disclosure will be held to the highest confidentiality.

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: _____
Are you taking any medications, supplements, or pills? ❑ Yes ❑ No If yes, please list: _____
Have you taken Phen-Fen or Redux? ❑ Yes ❑ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No _____

Are you on a special diet? ❑ Yes ❑ No
Have you/Do you use tobacco? ❑ Yes ❑ No If so, how many/how long?_____
Do you use controlled substances? ❑ Yes ❑ No

Women: Are you
Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs

❑ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ❑ Yes ❑ No	Cortisone Medicine ❑ Yes ❑ No	Hemophilia ❑ Yes ❑ No	Radiation Treatments ❑ Yes ❑ No
Alzheimer's Disease ❑ Yes ❑ No	Diabetes ❑ Yes ❑ No	Hepatitis A ❑ Yes ❑ No	Recent Weight Loss ❑ Yes ❑ No
Anaphylaxis ❑ Yes ❑ No	Drug Addiction ❑ Yes ❑ No	Hepatitis B or C ❑ Yes ❑ No	Renal Dialysis ❑ Yes ❑ No
Anemia ❑ Yes ❑ No	Easily Winded ❑ Yes ❑ No	Herpes ❑ Yes ❑ No	Rheumatic Fever ❑ Yes ❑ No
Angina ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	High Blood Pressure ❑ Yes ❑ No	Rheumatism ❑ Yes ❑ No
Arthritis/Gout ❑ Yes ❑ No	Epilepsy or Seizures ❑ Yes ❑ No	High Cholesterol ❑ Yes ❑ No	Scarlet Fever ❑ Yes ❑ No
Artificial Heart Valve ❑ Yes ❑ No	Excessive Bleeding ❑ Yes ❑ No	Hives or Rash ❑ Yes ❑ No	Shingles ❑ Yes ❑ No
Artificial Joint ❑ Yes ❑ No	Excessive Thirst ❑ Yes ❑ No	Hypoglycemia ❑ Yes ❑ No	Sickle Cell Disease ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Fainting Spells/Dizziness ❑ Yes ❑ No	Irregular Heartbeat ❑ Yes ❑ No	Sinus Trouble ❑ Yes ❑ No
Blood Disease ❑ Yes ❑ No	Frequent Cough ❑ Yes ❑ No	Kidney Problems ❑ Yes ❑ No	Spina Bifida ❑ Yes ❑ No
Blood Transfusion ❑ Yes ❑ No	Frequent Diarrhea ❑ Yes ❑ No	Leukemia ❑ Yes ❑ No	Stomach/Intestinal Disease ❑ Yes ❑ No
Breathing Problem ❑ Yes ❑ No	Frequent Headaches ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No	Stroke ❑ Yes ❑ No
Bruise Easily ❑ Yes ❑ No	Genital Herpes ❑ Yes ❑ No	Low Blood Pressure ❑ Yes ❑ No	Swelling of Limbs ❑ Yes ❑ No
Cancer ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No	Lung Disease ❑ Yes ❑ No	Thyroid Disease ❑ Yes ❑ No
Chemotherapy ❑ Yes ❑ No	Hay Fever ❑ Yes ❑ No	Mitral Valve Prolapse ❑ Yes ❑ No	Tonsillitis ❑ Yes ❑ No
Chest Pains ❑ Yes ❑ No	Heart Attack/Failure ❑ Yes ❑ No	Osteoporosis ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No
Cold Sores/Fever Blisters ❑ Yes ❑ No	Heart Murmur ❑ Yes ❑ No	Pain in Jaw Joints ❑ Yes ❑ No	Tumors or Growths ❑ Yes ❑ No
Congenital Heart Disorder ❑ Yes ❑ No	Heart Pacemaker ❑ Yes ❑ No	Parathyroid Disease ❑ Yes ❑ No	Ulcers ❑ Yes ❑ No
Convulsions ❑ Yes ❑ No	Heart Trouble/Disease ❑ Yes ❑ No	Psychiatric Care ❑ Yes ❑ No	Venereal Disease ❑ Yes ❑ No
			Yellow Jaundice ❑ Yes ❑ No

Have you ever had any serious illness not listed above? ❑ Yes ❑ No

Comments: _____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing INCORRECT or Omitting information can be dangerous my (or patient's) health. It is my responsibility to inform the periodontal office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date_____