MEDICAL / DENTAL HISTORY FORM

Patient Name________________________________ Date of Birth__________

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

Artificial / Prosthetic Heart Valve	NO	YES
History of Infective Endocarditis	NO	YES
Congenital Heart Disease / Defects	NO	YES
Heart Disease / Heart Attack	NO	YES
Pacemaker OR Implanted Defibrillator	NO	YES
High Blood Pressure	NO	YES
Chest Pains or Angina	NO	YES
Stroke	NO	YES
Artificial Joint(s)	NO	YES
Hepatitis / Liver Disease	NO	YES
Tuberculosis (TB)	NO	YES
Kidney Disease	NO	YES
Diabetes	NO	YES
Asthma	NO	YES
HIV	NO	YES
Arthritis	NO	YES
Osteoporosis	NO	YES
Radiation or Cancer Chemotherapy	NO	YES

Do you have, or have you had any disease, condition or problem not listed here?
NO YES

When was the last time you were hospitalized?

Have you had excessive or prolonged bleeding requiring special treatment?
NO YES

Do you have any known allergies? NO YES
Please list each one.

Do you currently smoke tobacco? NO YES Have you ever smoked tobacco? NO YES
Do you smoke non-tobacco products? NO YES

How much do you smoke daily?________________________________

Do you use smokeless tobacco? NO YES How frequently do you use it? ______________

Have you ever used smokeless tobacco? NO YES

Are you currently under the care of a physician(s)? YES NO

When were you last seen by a physician?______________________________

Name of physician______________________________

Street Address______________________________

Phone______________________________

Which **pharmacy** do you wish any prescriptions called in to?

Pharmacy Location (and phone number if possible).

Are you pregnant? ______________________ When is the estimated due date? ______________

Are you nursing? ______________

PERIODONTAL "GUM HEALTH" QUESTIONNAIRE

1) What is your chief concern, the reason for your visit to the periodontist? Please describe below.

2) Prior to your most recent visit, please estimate the last time you visited the dentist.______________

3) Prior to your most recent visit, please estimate the last time you had your teeth cleaned. ______________

4) Do you know anyone in your family who has been diagnosed with periodontal (gum) disease? NO YES

5) Have you ever been treated for periodontal disease in the past? NO YES

(a) Do you remember what treatment you had? If so, please describe.

(b) How long ago did you receive this/these treatment(s)?______________________________

6) Have you ever had a dental implant placed? NO YES Do you have multiple implants? NO YES

7) If so, how long ago were your dental implants placed? ______________________________

8) Have you ever had any problems with dental treatment in the past? If so please describe.

9) Do you have any other concerns you wish to speak about?

LIST OF CURRENT MEDICATIONS

Today's Date_______________________________

DRUG NAME	DOSE / FREQUENCY	REASON FOR TAKING

Please sign below to attest that the information provided is complete and correct.

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NAME DATE