PERIODONTICS NW MEDICAL DENTAL HEALTH HISTORY

Medical History

Patient name: _____

Medical alert (office use)

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

	Yes	No		Yes	No
Heart Problem	□	□	Glaucoma	□	□
Heart murmur	□	□	Do you smoke?	□	□
Rheumatic fever	□	□	If so, how much? _____ how long?_____		
Pacemaker	□	□	Do you drink alcohol?	□	□
Mitral valve prolapse	□	□	if so, how much? _____		
High blood pressure	□	□	Shortness of breath	□	□
Reaction or allergy to			Psychiatric treatment	□	□
Sulfa	□	□	Cancer/Tumors	□	□
Penicillin	□	□	Chemotherapy/radiation	□	□
Local anesthetics	□	□	Kidney disease	□	□
Aspirin/ibuprofen	□	□	Prostate problems (if male)	□	□
Codeine	□	□	Diabetes	□	□
Sedative/sleeping pills	□	□	Infectious diseases		
Latex or foods	□	□	Hepatitis	□	□
Other _____			Jaundice	□	□
Allergy problems			Tuberculosis	□	□
Hay fever	□	□	Herpes	□	□
Sinus problems	□	□	STD	□	□
Skin rashes	□	□	HIV positive/AIDS	□	□
Asthma	□	□	Bone or joint problems		
Hives	□	□	Arthritis	□	□
Blood problems			Joint replacement	□	□
Blood disease (anemia)	□	□	Osteoporosis	□	□
Easy bruising	□	□	Do you pre-medicate for dental		
Abnormal bleeding	□	□	appointments?	□	□
Intestinal problems			Women		
Ulcers	□	□	Are you pregnant?	□	□
Constipation/diarrhea	□	□	Taking birth control pill		
Fainting, seizures, or epilepsy	□	□	or hormones	□	□
Thyroid problems	□	□	Are you nursing?	□	□
			Past menopause	□	□

Please explain if any of the above are answered yes: _____

_____

_____

Physician's name _____ Phone # ____(____)_____

Clinic/hospital _____ Date of last physical ____/____/____

Prescription medications, over the counter medications, and herbal supplements:

1) _____ for? _____ 4) _____ for? _____

2) _____ for? _____ 5) _____ for? _____

3) _____ for? _____ 6) _____ for? _____

Dental History

When was your last dental cleaning? _____ How often do you brush? _____floss?_____

Have you ever been treated for periodontal disease? Yes □ No □, When? _____

Have you had orthodontic treatment? Yes □ No □, When? _____

Your signature x_____ Date ____/___/____

Reviewed by _____ Date ____/___/____ Reviewed by _____ Date ___/___/____

Reviewed by _____ Date ____/___/____ Reviewed by _____ Date ___/___/____