ASSOCIATES IN PERIODONTICS
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MEDICAL HISTORY

Name____ **Date of Birth**______________________

Health problems that you may have, or medications you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Date of last physical______________________
Physician's Name and Address:

Y N Do you use tobacco? Amt.?_____ Duration___________
Y N Do you drink more than 3 alcoholic beverages per day?
Y N Do you use recreational drugs?
Y N Are you taking any medications, pills or drugs? If so what
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Y N Are you in good health?
Y N Have you ever had a serious head or neck injury?
Y N Have you ever had a major operation? For?____________
Y N Have you ever been hospitalized? For?________________

Women Only

Y N Are you taking oral contraceptives?
Y N Are you pregnant or trying to become so?
Y N Are you nursing?

Are you allergic to any of the following?
Aspirin Penicillin Latex Any metals Dental novocaine Acrylic Other_____________

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

AIDS/HIV
Alzheimer's
Anaphylaxis
Anemia
Angina
Arthritis
Artificial heart valve
Artificial joint
Asthma
Blood disease
Blood transfusion
Breathing problem
Bruise easily
Cancer
Chemotherapy
COVID19

Chest pains
Cold sores/fever blisters
Congenital heart disorder
Convulsions
Cortisone medication
Diabetes
Drug addiction
Easily winded
Emphysema
Epilepsy or seizures
Excessive bleeding
Excessive thirst
Fainting or dizziness
Frequent cough
Frequent diarrhea

Frequent headaches
Genital herpes
Glaucoma
Hay fever
Heart Attack
Heart Disease
Heart Murmur
Heart pace maker
Hemophilia
Hepatitis A
Hepatitis B or C
High Blood Pressure
Hives or rash
Hypoglycemia
Irregular heart beat

Kidney problems
Leukemia
Liver disease
Low blood pressure
Lung disease
Migraine headaches
Mitral valve prolapse
Pain in jaw joints
Parathyroid disease
Psychiatric care
Radiation treatments
Recent weight loss
Renal dialysis
Rheumatic fever
Rheumatisim

Scarlet fever
Shingles
Sickle cell disease
Sinus trouble
Spina bifida
Stomach/intestinal
Stroke
Swelling of limbs
Thyroid disease
Tonsilitis
Tuberculosis
Tumors or growths
Ulcers
Venereal disease
Yellow jaundice
Other__________

DENTAL HISTORY

Who is your regular dentist?________________________
Who referred you to see us?________________________
When did you last see a dentist?______________________
What was the reason for your visit?____________________
How often do you have your teeth cleaned?______________
How frequently do you brush your teeth?________________

How frequently do you floss?________
What else do you use to clean your teeth?_________________
Have family members lost teeth? Y N
Do you clench your teeth? Y N
Have you had previous gum treatment? Y N
Have you had previous braces treatment? Y N

Have you had a complete series of dental x-rays (20 shots) taken within the last 3 years?....... Y....... N......When?

Do you have the following:

Bleeding gums
Swollen gums
Sensitive teeth
Pain in jaw, head or neck

Clicking jaw
Lip or cheek biting
Loose teeth
Teeth that have migrated

Food catching between teeth
Bad taste in your mouth
Bad breath
Difficulty chewing

Gum or tooth abscess
Extractions or missing teeth
Impacted teeth
Plates or dentures
Dental Implants

Are you interested in:

Replacing missing teeth
Whitening your teeth
Dental implant treatment

Halitosis (bad breath) treatment
Snoring treatment for yourself
Snoring treatment for your significant other

Migraine headache treatment
Straightening your teeth
None of the above

Authorization and release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered to my satisfaction. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor______________________________ Today's Date______________