



MEDICAL / DENTAL HISTORY FORM

Patient Name _____

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

Rheumatic fever or rheumatic heart disease	NO	YES
Mitral valve prolapse or heart murmur	NO	YES
Heart disease / heart attack	NO	YES
Artificial heart valve	NO	YES
Irregular heart beat	NO	YES
Pacemaker	NO	YES
High Blood Pressure	NO	YES
Chest pains or angina	NO	YES
Stroke	NO	YES
Artificial joint	NO	YES
Hepatitis / Liver disease	NO	YES
Tuberculosis (TB)	NO	YES
Thyroid trouble	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?

When was the last time you were hospitalized?

Have you had excessive or prolonged bleeding requiring special treatment?

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?

How much do you smoke daily? _____

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

Are you currently under the care of a physician(s)?

When were you last seen by a physician? _____

Name of physician _____

Street Address _____

City, State, and Zip Code _____

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 QUESTIONNAIRE

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

Please estimate the last time you visited the dentist. _____

Please estimate the last time you had your teeth cleaned. _____

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

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

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

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

If so, how long ago were your dental implants placed? _____

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

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

