Periodontal Health Professionals

Medical History

PATIENT NAME _____ DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of you entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No ○ N/A _____
Medical Doctor's Name _____ Phone Number _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No ○ N/A _____
Have you ever had a serious head or neck injury? ○ Yes ○ No ○ N/A _____
Do you take, or have taken, Phen-Fen or Redux? ○ Yes ○ No ○ N/A _____
Do you drink more than 2 alcoholic beverages per day? ○ Yes ○ No ○ N/A _____
Do you use tobacco? ○ Yes ○ No ○ N/A If yes, how much? _____
Do you use controlled substances? ○ Yes ○ No ○ N/A _____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

Do you have, or have you had, any of the following? (please check only those that apply)

☐ AIDS/HIV Positive	☐ Congenital Heart Disease	☐ Heart Pace Maker*	☐ Psychiatric Care
☐ Alzheimer's Disease	☐ Convulsions	☐ Heart Trouble/Disease	☐ Radiation Treatments
☐ Anaphylaxis	☐ Cortisone Medicine	☐ Hemophilia	☐ Recent Weight Loss
☐ Anemia	☐ Diabetes	☐ Hepatitis A	☐ Renal Dialysis
☐ Angina	☐ Easily Winded	☐ Hepatitis B or C	☐ Rheumatic Fever*
☐ Arthritis/Rheumatism	☐ Emphysema	☐ Herpes	☐ Scarlet Fever
☐ Artificial Heart Valve*	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Shingles
☐ Artificial Joint*	☐ Excessive Bleeding	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spell/Dizziness	☐ Hypoglycemia	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Stomach Disease
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Kidney Problems	☐ Stroke
☐ Breathing Problem	☐ Frequent Headaches	☐ Leukemia	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Liver Disease	☐ Tuberculosis
☐ Cancer	☐ Glaucoma	☐ Low Blood Pressure	☐ Tumors or Growths
☐ Chemotherapy	☐ Hay Fever	☐ Lung Disease	☐ Stomach Ulcers
☐ Chest Pains	☐ Heart Attack/Failure	☐ Mitral Valve Prolapse*	☐ Venereal Disease
☐ Cold Sores/Fever Blisters	☐ Heart Murmur*	☐ Parathyroid Disease	☐ Yellow Jaundice

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

Are you currently taking any medications, vitamins, and/or herbs?(please list) _____

Do you take aspirin, or any blood thinner, daily? ○ Yes ○ No _____

Why are you seeking periodontal treatment? _____
Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ○ Yes ○ No
Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

(please complete reverse side)

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

Bleeding/Sore gums	○Yes	No○	Loose teeth	○Yes	No○
Unpleasant taste/bad breath	○Yes	No○	Sensitive to hot	○Yes	No○
Burning tongue/lips	○Yes	No○	Sensitive to cold	○Yes	No○
Frequent blisters, lips/mouth	○Yes	No○	Sensitive to sweet	○Yes	No○
Swelling/lumps in mouth	○Yes	No○	Sensitive to biting	○Yes	No○
Ortho treatment (braces)	○Yes	No○	Food impaction	○Yes	No○
Biting cheeks/lips	○Yes	No○	Clenching/grinding	○Yes	No○
Clicking/popping jaw	○Yes	No○	Shifting of teeth	○Yes	No○
Pain in jaw joint (open/close)	○Yes	No○	Change in bite	○Yes	No○

Oral Hygiene:

Do you use the following? ☐Toothbrush ☐Dental Floss ☐Fluoride Rinse ☐Other

How often do you brush? _____ Brush is: ☐Soft ☐Medium ☐Hard

Your Dentist _____ How long? _____

Date of last dental visit? _____ Date of last cleaning? _____

Comments: _____

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

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

_____ _____

DOCTOR'S SIGNATURE DATE

MEDICAL HISTORY UPDATE INFORMATION

DATE	CHANGES OF MEDICAL HISTORY	PT INITIALS