MEDICAL HISTORY

This information is necessary for proper evaluation of your periodontal health. Answers to the following questions are for our records only and will be considered confidential.

Check one:

YES	NO		
		1.	My last physical examination was on _____
☐	☐	2.	Has there been any change in your general health within the past year?
☐	☐	3.	Are you now under the care of a physician?
			If so, what is the condition being treated? _____
☐	☐	4.	Have you had any serious illness or operation?
			If so, what was the illness or operation? _____
☐	☐	5.	Have you been hospitalized or had a serious illness within the past five (5) years?
		6.	Do you have or have you had any of the following diseases or problems?
☐	☐	a.	Have you had a total joint replacement?
☐	☐	b.	Rheumatic fever or rheumatic heart disease?
☐	☐	c.	Congenital heart lesion or heart murmur?
☐	☐	d.	Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, low blood pressure, arteriosclerosis, stroke)?
☐	☐	e.	Asthma, hay fever, or seasonal allergies?
☐	☐	f.	Hives or a skin rash?
☐	☐	g.	Fainting spells or seizures?
☐	☐	h.	Diabetes?
☐	☐	i.	Hepatitis, jaundice, or liver disease?
☐	☐	j.	Are you H.I.V. Positive or have AIDS?
☐	☐	k.	Arthritis?
☐	☐	l.	Inflammatory rheumatism (painful swollen joints)?
☐	☐	m.	Stomach ulcers?
☐	☐	n.	Kidney trouble?
☐	☐	o.	Tuberculosis?
☐	☐	p.	Venereal disease?
☐	☐	q.	History of cancer or radiation therapy?
☐	☐	r.	Other? _____
☐	☐	7.	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
☐	☐	8.	Do you have any blood disorder, such as anemia?
☐	☐	9.	Have you had any surgery or x-ray treatment for a tumor or growth?
☐	☐	10.	Are you taking any drug or medication?
			If so, what _____
		11.	Are you taking any of the following?
☐	☐	a.	Antibiotics
☐	☐	b.	Anticoagulants (blood thinners)
☐	☐	c.	Medicine for high blood pressure
☐	☐	d.	Cortisone (steroids)
☐	☐	e.	Tranquilizers
☐	☐	f.	Aspirin
☐	☐	g.	Insulin, Tolbutamide (orinase), or similar drug
☐	☐	h.	Digitalis or drugs for heart trouble
☐	☐	i.	Nitroglycerin
☐	☐	j.	Bisphosphonates (oral/IV)
☐	☐	k.	Other _____
		12.	Are you allergic to or have you reacted adversely to:
☐	☐	a.	Local anesthetics
☐	☐	b.	Penicillin, Erthromycin, Tetracyclines or other antibiotics
☐	☐	c.	Sulfa drugs
☐	☐	d.	Barbiturates, sedatives, or sleeping pills
☐	☐	e.	Aspirin
☐	☐	f.	Codeine
☐	☐	g.	Demerol
☐	☐	h.	Other _____
☐	☐	13.	Have you had any serious trouble associated with any previous dental treatment?
☐	☐	14.	Do you have any disease, condition , or problem not listed above that you think I should know about?
			If so, please explain _____
☐	☐	15.	Do you smoke? If so, how much? _____
☐	☐	16.	Do you have a history of alcohol/drug abuse? Explain: _____

WOMEN

☐	☐	17.	Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?
☐	☐	18.	Are you pregnant or breastfeeding?
☐	☐	19.	Do you have any problems associated with your menstrual period?
☐	☐	20.	Are you taking any birth control medication?
☐	☐	21.	Have you reached your menopause?