PERIODONTAL SURGICAL ARTS

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YOUR NAME _____ **Date of Birth** _____

Although our periodontal specialty focuses on oral medicine, your oral cavity is part of your overall health. Any health problems you have or medications that you may be taking can have important interrelationship with your dental care. Thank you for answering the following questions. Your disclosure will be held to the highest confidentiality.

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: _____
Are you taking any medications, supplements, or pills? ❑ Yes ❑ No If yes, please list: _____
Have you taken Phen-Fen or Redux? ❑ Yes ❑ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No _____
Are you on a special diet? ❑ Yes ❑ No
Have you ever used tobacco? Do you use tobacco? ❑ Yes ❑ No If so, how much/how long? _____
Do you use controlled substances? ❑ Yes ❑ No

Women: Are you
Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Shellfish ❑ Eggs

❑ Other. If yes, please explain: _____

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

AIDS/HIV Positive	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Drug Addiction	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Rheumatism	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Easily Winded	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Excessive Bleeding	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Excessive Thirst	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Sleep Apnea	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Fainting Spells/Dizziness	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Stomach/Intestinal Disease	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Breathing Problems	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Cold Sores/Fever Blisters	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Congenital Heart Disease	❑ Yes ❑ No	Heart Trouble/Disease	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Convulsions	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No		
Cortisone Medications	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No		

Have you ever had any serious illnesses not listed above? ❑ Yes ❑ No

Comments: _____

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

Signature of Patient, Parent, or Guardian _____ **Date** _____