



Cary Periodontics and Implant Dentistry

DENTAL & MEDICAL HISTORY FORM

Patient Name(Dr./Mr./Mrs./Ms.) _____ DOB: _____

DENTAL HISTORY

NAME OF DENTIST: _____

How long have you been with your present dentist?: _____

How many times were your teeth cleaned in the past 2 years? _____ When was the last time? _____

Have you had previous periodontal treatment? YES NO

If yes, by whom and when? _____

Are your teeth sensitive to heat, cold, or sweets? YES NO

Do your gums bleed? YES NO

Are you aware of grinding your teeth at night in your sleep? YES NO

Have you had your teeth straightened? If yes, by whom and when? _____ YES NO

MEDICAL HISTORY

NAME OF PHYSICIAN: _____ Phone #: _____

Date of last physical exam _____ Do you consider your general health to be good? YES NO

Has your general health changed in the past year? _____ YES NO

Have you ever had any serious illness or major operations? _____ YES NO

Have you had abnormal bleeding associated with previous surgery, trauma, or tooth extraction? YES NO

Do you smoke? If yes, what do you smoke and how much? _____ YES NO

Have you been diagnosed with osteoporosis or taken any bone altering/preserving medications? YES NO

Are you allergic to or have you had any adverse reaction to any of the following:

- Dental anesthetics YES NO
- Antibiotics: _____ YES NO
- Aspirin YES NO
- Anti-inflammatory drugs YES NO
- Narcotics: _____ YES NO
- Valium or tranquilizers YES NO
- Latex YES NO
- Other Drugs: _____ YES NO

For women only:

Are you pregnant at the present time or are planning on becoming pregnant in the near future? YES NO

Are you taking any oral contraceptives? YES NO

Have you reached menopause? YES NO Are you taking hormones? YES NO

For Office Use Only:

Patient Name: _____ DOB: _____

MEDICAL HISTORY (Continued)

Do you have or have you had any of the following conditions:

Anemia	YES NO	Diabetes	YES NO	Sinus Trouble	YES NO
Blood Disease	YES NO	Thyroid Disease	YES NO	Bladder Trouble	YES NO
Bleeding Problems	YES NO	Kidney Trouble	YES NO	Bowel Disease	YES NO
Heart Disease	YES NO	Ulcers	YES NO	Skin Disease	YES NO
High Blood Pressure	YES NO	Malignancy/Cancer	YES NO	Glaucoma	YES NO
Low Blood Pressure	YES NO	Radiation Therapy	YES NO	Epilepsy/Seizures	YES NO
Heart Murmur	YES NO	Chemotherapy	YES NO	Tuberculosis	YES NO
Lung/Pulmonary	YES NO	Osteoporosis	YES NO	Venereal Disease	YES NO
Artificial Heart Valve	YES NO	Artificial Joints	YES NO	Mental Illness	YES NO
Pacemaker	YES NO	Arthritis	YES NO	Hepatitis	YES NO
Stroke	YES NO	Liver Disease	YES NO	HIV Positive	YES NO
Asthma	YES NO	Rheumatic Fever	YES NO	Rheumatism	YES NO

Other (please specify): _____

Please list any current medications you are taking or attach list if necessary:

Patient (or responsible party) Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

For Office Use Only:

MEDICAL HISTORY UPDATE (to be completed at returning visits):

Update (include any changes in health and/or medications): _____

Patient Signature: _____ Date: _____ Provider Initials: _____

Update (include any changes in health and/or medications): _____

Patient Signature: _____ Date: _____ Provider Initials: _____

Update (include any changes in health and/or medications): _____

Patient Signature: _____ Date: _____ Provider Initials: _____

Update (include any changes in health and/or medications): _____

Patient Signature: _____ Date: _____ Provider Initials: _____