Cary Periodontics & 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 #:_____

Name of Pharmacy:_____ Address:_____ 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
Sleep Apnea	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:_____