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

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 currently or have you previously smoked tobacco products? _________________________ 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 Office Use Only:

Patient Name:____ **DOB:**____________________

MEDICAL HISTORY (Continued)

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

Condition			Condition		
Anemia	YES	NO	Diabetes	YES	NO
Clotting Disorder	YES	NO	Hypothyroidism	YES	NO
DVT	YES	NO	Renal Disease	YES	NO
Pulmonary Embolism	YES	NO	Acid Reflux	YES	NO
Atrial Fibrillation	YES	NO	Bowel Disorder	YES	NO
Heart Disease	YES	NO	Osteoporosis	YES	NO
Hypertension	YES	NO	Bisphosphonate Use	YES	NO
Artificial Heart Valve	YES	NO	Osteoarthritis	YES	NO
Pacemaker	YES	NO	Artificial Joints	YES	NO
Stroke	YES	NO	Rheumatoid Arthritis	YES	NO
Heart Attack	YES	NO	Liver Disease	YES	NO
COPD	YES	NO	Hepatitis	YES	NO
Asthma	YES	NO	Cancer	YES	NO
Sleep Apnea	YES	NO	HIV	YES	NO
Anxiety	YES	NO	Tuberculosis	YES	NO
Depression	YES	NO	Epilepsy/Seizures	YES	NO
Mental Illness	YES	NO	Chronic Sinusitis	YES	NO
Other	YES	NO	Glaucoma	YES	NO

For women only:

Question		
Are you pregnant?	YES	NO
Are you taking oral contraceptives?	YES	NO
Have you reached menopause?	YES	NO
If yes, are you taking hormone therapy?	YES	NO

Please provide additional information as needed:____

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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: