Creating Healthy Smiles
Dr. Fred Alger
PERIODONTICS & DENTAL IMPLANTS
www.drfredalger.com

PATIENT MEDICAL AND DENTAL HISTORY

Full Name _____ Age ___ S.S. # _____ Date _____

1. Please list any prescription or non-prescription medications that you are taking, and the reason why.

Medication:	Reason:

2. Do you now have, or have you ever had any of the following conditions? (Check all that apply)

- ☐ High Blood Pressure
- ☐ Diabetes (High Blood Sugar)
- ☐ Ulcers or Stomach Trouble
- ☐ Stroke, Aneurysm
- ☐ HIV Positive
- ☐ Chest Pain
- ☐ Heart Attack, Heart Disease
- ☐ Heart Valve Trouble, Murmur
- ☐ Alcohol or Drug Dependence
- ☐ Lung Disorders
- ☐ Thyroid Problems
- ☐ Rheumatic Fever
- ☐ Psychiatric Treatment
- ☐ Kidney or Bladder Trouble
- ☐ Glaucoma
- ☐ Blood Disorder, Anemia
- ☐ Currently Pregnant or Nursing
- ☐ Sinus Trouble
- ☐ Abnormal Bleeding
- ☐ Tumor or Growth
- ☐ Cancer
- ☐ Fainting, Epilepsy, Seizures
- ☐ Frequent Headaches
- ☐ Cold Sores or Oral Herpes
- ☐ Tuberculosis
- ☐ Recurrent Pain in Face
- ☐ Clicking or Popping of Jaws
- ☐ Hepatitis, Liver Disease
- ☐ Asthma, Hay Fever
- ☐ Arthritis, Joint Surgery
- ☐ Wisdom Teeth Removed
- ☐ Orthodontics (Braces)
- ☐ None of the Above

3. Are you allergic to, or had an adverse reaction to any of the following medications? Check below.

- ☐ Penicillin or other antibiotics
- ☐ Tranquilizers (i.e. Valium)
- ☐ Aspirin, Ibuprofen (i.e.Advil, Motrin)
- ☐ Barbiturates (sleeping pills)
- ☐ Nubain, Demerol (Narcotics)
- ☐ Local Anesthetics (Novocaine, Lidocaine, Carbocaine)
- ☐ Codeine, Vicodin
- ☐ Versed (Midazolam)
- ☐ Other _____

If yes to any of the above, please explain.

☐ No ☐ Yes 4. Have you ever had a serious accident or been hospitalized? If yes, please explain.

☐ No ☐ Yes 5. Are you currently under the care of a physician? If so, for what condition?

☐ No ☐ Yes 6. Do you smoke cigarettes, cigars or chew tobacco? If you smoke, how much daily?

☐ No ☐ Yes 7. Do you take aspirin daily? _____

☐ No ☐ Yes 8. Do you have any other medical conditions, or is there any other health information that you feel Dr. Alger should be made aware of? _____

DENTAL HISTORY

☐ No ☐ Yes 9. Do you have any dental condition that you believe requires immediate attention today?
If so, please explain. _____

_____

☐ No ☐ Yes 10. Do your gums bleed? If yes, when? _____

_____

☐ No ☐ Yes 11. Did either of your parents lose most or all of their teeth? Which parent? _____

_____

☐ No ☐ Yes 12. Have you ever been treated for gum disease *(i.e. deep scaling, root planing, gum surgery)*?
If yes, please explain. _____

_____

☐ No ☐ Yes 13. Have you had any serious trouble with previous dental treatment? If yes, please explain.

_____

☐ No ☐ Yes 14. Are you nervous about dental treatment? _____

☐ No ☐ Yes 15. Do you use dental floss? If so, how often? _____

16. How often do you brush your teeth? _____

17. What type of toothbrush do you use? Please check below.
☐ Hard Bristle Brush ☐ Medium Brush ☐ Soft Brush ☐ Electric _____

18. Who is your dentist? _____

19. How long have you been a patient of your current dentist? _____

20. What is your primary reason for coming to the periodontist? _____

_____

21. How upset would you be if you lost your teeth and had to wear dentures? Check below.
☐ Very Upset ☐ Somewhat Upset ☐ Not Very Upset

22. What is the most important thing that you want Dr. Alger to know about you or about the health of your mouth? _____

_____

IN OFFICE NOTES: _____

To the best of my knowledge, the above answers are true and correct. If I ever have a change in my health or medications, I will inform Dr. Alger at the next appointment.

Signature _____ Date _____