

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)

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

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Codeine, Vicodin |
| <input type="checkbox"/> Tranquilizers (i.e. Valium) | <input type="checkbox"/> Nubain, Demerol (Narcotics) | <input type="checkbox"/> Versed (Midazolam) |
| <input type="checkbox"/> Aspirin, Ibuprofen (i.e. Advil, Motrin) | <input type="checkbox"/> Local Anesthetics (Novocaine, Lidocaine, Carbocaine) | <input type="checkbox"/> 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? _____

(OVER) 

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: _____
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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 _____