PROGRESSIVE PERIODONTICS & IMPLANT DENTISTRY

## Health Information

NAME: _____

**I. Circle appropriate answer** *(Leave blank if you do not understand the question)*

1. Yes / No Are you in pain now?
   If YES, explain _____
2. Yes / No Is your general health good?
   If NO, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes / No Are you being treated by a physician now?
   If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last exam? _____ Name of treating dentist _____
6. Yes / No Has there been a change in your health within the last year?
   If YES, explain _____

**II. Have you experienced any of the following *(Please circle Yes or No for each)***

| | | |
|---|---|---|
| Yes / No Chest pain | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night Sweats | Yes / No Ringing in the ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

**III. Have you had or do you have any of the following? *(Please circle Yes or No for each)***

| | | |
|---|---|---|
| Yes / No Heart disease | Yes / No Cosmetic surgery | Yes / No Eating disorder |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Heart attack | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Artificial joint | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Stomach problems or ulcers | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart defects | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Heart murmurs | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Rheumatic fever | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Skin disease | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No Hardening of the arteries | | Yes / No Eye disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Transplants |
| Yes / No Seizures | Yes / No Stroke | Yes / No Tuberculosis |

**This information will not be released unless specifically authorized by patient**

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

**IV. Are you allergic to or have you had a reaction to any of the following?** *(Please circle Yes or No for each)*

| | | |
|---|---|---|
| Yes / No Aspirin | Yes / No Valium | Yes / No Vicodin |
| Yes / No Darvon | Yes / No Demerol | Yes / No Percodan |
| Yes / No Codeine | Yes / No Penicillin | Yes / No Nitrous oxide |
| Yes / No Latex | Yes / No Food | Yes / No Metal |
| Yes / No Local anesthetic (Novocaine or Xylocaine) | Yes / No Erythromycin<br>Yes / No Tetracycline | OTHER: _____ |

**V. Are you taking or have you taken any of the following in the last three months?** *(Please circle Yes or No for each)*

| | | |
|---|---|---|
| Yes / No Bisphosphonate (Fosamax) | Yes / No Tobacco in any form | Yes / No Supplements |
| Yes / No Over-the-counter medicines | Yes / No Alcohol | Yes / No Aspirin |
| Yes / No Weight loss medications | Yes / No Recreational drugs | |
| Yes / No Corticosteroids | Yes / No Antibiotics | |

Please list all medications you are currently taking: _____

**VI. Women only** *(Please circle Yes or No for each)*

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you Nursing?
Yes / No Are you taking birth control pills?

**VII. All patients** *(Please circle Yes or No for each)*

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, explain: _____
_____
Yes / No Have you ever been pre-medicated for dental treatment?
If YES, explain: _____
Yes / No Have you ever taken Fen-Phen
If YES, when: _____
Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the doctor of any change in my health and/or medication. Further, I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____
Signature of Patient (Parent/Guardian) Date Signature of Dentist Date

**To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.**

_____
***Signature of Patient, Parent or Guardian*** ***Date***