

WEST VALLEY PERIODONTICS

MEDICAL HISTORY

Do you have any serious medical conditions that we should be aware of? Yes___ No___

If yes, please describe: _____

Are you currently being treated by a physician for any medical condition? Yes___ No___

If yes, please describe: _____

Name of Physician:_____ Address:_____ Phone:_____

Please list any medications you are currently taking:_____

Have you been hospitalized or had any operations in past two years? Yes ___ No___

If yes, when & why?_____

Do you have any allergies or sensitivity to any medication? Yes___ No___

Please list:_____

Do you smoke? Yes___ No___ How much in a day?_____

Do you use chewing tobacco? Yes___ No___ How much in a day?_____

Have you ever had any complications following dental treatment? Yes___ No___

If yes, please describe: _____

WOMEN: Are you pregnant? Yes___ No___ Do you suspect that you could be? Yes___ No___

If yes how far along are you? _____ Are you nursing or lactating? Yes___ No___

***please note that effectiveness of oral contraceptive can be impaired by antibiotics used*

Have you ever had any of the following? Please check those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies
Describe:_____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorder
Describe:_____ |
| <input type="checkbox"/> Artificial Joint
Date:_____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Describe:_____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Blood Disease
Describe:_____ | <input type="checkbox"/> Heart Attack
Date:_____ | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Thinner Meds
Name:_____ | <input type="checkbox"/> Heart Surgery
Date:_____ | <input type="checkbox"/> Stroke
Date:_____ |
| <input type="checkbox"/> Bisphosphonate Meds
Name:_____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Replacement
Date:_____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other
_____ |

To the best of my knowledge, all preceding answers and information provided are true and correct. I authorize West Valley Periodontics to contact my family physician and/or any medical specialist that I have listed above to obtain further medical information if necessary. If I ever have any change in my health, I will inform the office as soon as possible.

PRINTED NAME OF PATIENT

DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

DOCTOR SIGNATURE

DATE