Southdale Periodontics
Medical History

Patient Name: _____ Birth Date: _____ Today's Date: _____

Do you require an antibiotic premedication before dental appointments? If so, name and dosage?	○ Yes ○ No	If yes
Did you take your antibiotic premedication today?	○ Yes ○ No	
Are you now under the care of a physician? If so, what is the condition being treated?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a serious illness?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do/Did you smoke cigarettes, cigars, E-cigarettes or use smokeless tobacco? Type/frequency/duration?	○ Yes ○ No	If yes
Have you quit using tobacco? If so, when?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant / Trying? ☐ Breastfeeding? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Local Anesthetics	☐ Sedatives	☐ Barbituates	☐ Penicillin
☐ Other Antibiotics	☐ Sulfa Drugs	☐ Aspirin	☐ Ibuprofen
☐ Codiene	☐ Latex	☐ Metal	☐ Acrylic
☐ No Known Allergies	☐ Other?		

Do you have, or have you experienced?

Tiring Easily/ Weakness	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Arthritis	○ Yes ○ No
Marked weight change	○ Yes ○ No	Emphysema	○ Yes ○ No	Artificial joints	○ Yes ○ No
Night sweats	○ Yes ○ No	Asthma / Hay fever	○ Yes ○ No	Osteoporosis / Osteopenia	○ Yes ○ No
Persistent fever	○ Yes ○ No	Persistant cough	○ Yes ○ No	Hepatitis	○ Yes ○ No
Skin Eruptions (rash) hives	○ Yes ○ No	Sputum production (phlegm)	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Change in skin color	○ Yes ○ No	Coughing up bloody sputum	○ Yes ○ No	Ulcers	○ Yes ○ No
Significant vision changes	○ Yes ○ No	Difficulty breathing	○ Yes ○ No	Blood clotting disorder	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Kidney Problem	○ Yes ○ No
Loss of hearing	○ Yes ○ No	Thyroid condition/ Goiter	○ Yes ○ No	Increase in freq of urination	○ Yes ○ No
Ringing in ears	○ Yes ○ No	Rheumatic fever	○ Yes ○ No	Herpes	○ Yes ○ No
Frequent nosebleeds	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Venereal disease	○ Yes ○ No
Sinus problems	○ Yes ○ No	Chest pain / Discomfort	○ Yes ○ No	Bruise easily	○ Yes ○ No
Throat soreness/Hoarseness	○ Yes ○ No	Heart attack / Failure	○ Yes ○ No	Anemia	○ Yes ○ No
Stroke	○ Yes ○ No	Shortness of breath	○ Yes ○ No	Blood transfusion	○ Yes ○ No
Headaches	○ Yes ○ No	Swelling of ankles	○ Yes ○ No	Radiation Therapy	○ Yes ○ No
Convulsions / Epilepsy	○ Yes ○ No	High blood pressure	○ Yes ○ No	Tumors or growths	○ Yes ○ No
Numbness / Tingling	○ Yes ○ No	Congential heart disorder	○ Yes ○ No	Cancer	○ Yes ○ No
Dizziness / Fainting	○ Yes ○ No	Artificial heart valve	○ Yes ○ No	Ever been tested for HIV	○ Yes ○ No
Psychiatric treatment	○ Yes ○ No	Pace maker	○ Yes ○ No	HIV	○ Yes ○ No

Have you ever had any other disease, condition or problem not listed above?	○ Yes ○ No	If yes

Are you taking any of the following?

Antibiotics / Sulfa drugs	○ Yes ○ No	Antihistamines/Allergy drugs	○ Yes ○ No	Insulin	○ Yes ○ No
Blood thinners	○ Yes ○ No	Bisphosphonate(ie.fosomax)	○ Yes ○ No	Recreational drugs	○ Yes ○ No
Blood pressure medication	○ Yes ○ No	Cholesterol medications	○ Yes ○ No	Digitalis / Heart medication	○ Yes ○ No
Thyroid medicine	○ Yes ○ No	Herbal / Homeopathic	○ Yes ○ No	Nitroglycerin	○ Yes ○ No
Cortisone / Steroids	○ Yes ○ No	Tranquilzers	○ Yes ○ No	Aspirin	○ Yes ○ No

1) Please list/attach all medications and dosages: _____

_____

_____

_____

2) Have you been diagnosed with Dementia or Alzheimer's Disease? □ **Yes** □ **No** If so, what and when?

_____

(Please update your HIPAA consent form to discuss treatment with your designated care givers or power of attorney.)

3) For diabetics: What was your last A1C level? _____ What was your morning glucose level? _____

4) General Dentist's Name: _____ Phone: _____

5) Frequency of dental cleanings: _____ 6) Date of last dental visit? _____

7) How often do you: Brush? _____ Floss? _____ 8) Toothbrush is: □soft □medium □hard □electric

9) Do you have tooth or gum pain? □ **Yes** □ **No** _____

10) Do you wear a night or bite guard? □ **Yes** □ **No**

11) Have you ever been treated for gum disease or gum/bone loss in the past? □ **Yes** □ **No** If so, where, what & when? _____

12) Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely

13) Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? □ **Yes** □ **No** _____

14) Have you ever had any serious trouble associated with previous dental treatment? □ **Yes** □ **No**

_____

15) Is there anything you would like to discuss with the doctor in private? □ **Yes** □ **No**

16) MOUTH	**Y**	**N**	16) TEETH	**Y**	**N**
Bleeding, sore gums	□	□	Loose teeth	□	□
Unpleasant taste/bad breath	□	□	Sensitive to hot	□	□
Burning tongue/lips	□	□	Sensitive to cold	□	□
Frequent blisters, lips/mouth	□	□	Sensitive to sweets	□	□
Swelling/lumps in mouth	□	□	Sensitive to biting	□	□
Ortho treatment (braces)	□	□	Food impaction	□	□
Biting cheeks/lips	□	□	Clenching/grinding	□	□
Clicking/popping jaw	□	□	Shifting of teeth	□	□
Difficulty opening/closing jaw	□	□	Change in bite	□	□

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the periodontist at the next appointment.

Patient Name (Print): _____ Birth Date: _____

Signature of Patient/Parent/Guardian: _____ Date: _____