FREDERICK PERIODONTAL ASSOCIATES MEDICAL AND DENTAL HISTORY

Patient's Name:_____/_____/_____ Male ☐ Female☐ Date: _____

Date of Birth: _____/ _____/ _____ Age: _____ Weight: _____ Height: _____

Patient's Current Dentist: _____ Date of Last Appt.: _____

Patient's Current Physician: _____ Date of Last Appt.: _____

Referred to Our Office By: ☐ Self: ***Where did you hear of us:*** ☐*Facebook* ☐*Internet* ☐*Ad- where:*_____ ☐ Dentist

All past medical and dental history are important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions. Additional space has been allowed on the bottom of this form for your use in fully explaining complex medical problems or concerns. Thank you!

Please list any medical problems you have: _____

_____

Please list CURRENT MEDICATIONS (including non-prescriptions/ alternative/ herbal): _____

_____

Please list all DRUG ALLERGIES (including past and present): _____

Please list all PREVIOUS SURGERIES OR HOSPITALIZATIONS: _____

_____

Please check all conditions below that apply with a checkmark to indicate YES:

☐High blood pressure
☐Chest pains or heart attack
☐Use tobacco (types & how much: _____)
☐Stroke
☐Rheumatic fever
☐Shortness of breath or swollen ankles
☐Heart trouble, murmur, mitral valve prolapsed
☐Prosthetic devices (heart, valve, hip, etc.)
☐Lung diseases (TB, emphysema, etc.)
☐Asthma
☐Allergies or hay fever
☐Sinus Problems
☐Mouth breathing or excessive snoring
☐Ulcers or stomach problems
☐Diabetes
☐Hepatitis or liver disease
☐Thyroid problems
☐Connective tissue disease
☐Arthritis or rheumatism
☐Cancer (type and year: _____)
☐Subject to prolonged bleeding or bruise easily
☐ Serious illness not listed: _____
☐Glaucoma
☐Epilepsy, convulsions, or seizure history
☐Psychiatric therapy or emotional problems
☐Pregnant or possibly pregnant
☐Sexually transmitted disease

☐Taking diet pills (prescription or non-prescription)
☐Pain, popping, catching, locking in jaw joints
☐Clench or grind teeth
☐Wake up with sore jaws
☐Frequent headaches (how many per wk.: _____)
☐Consume alcoholic beverages
☐Dizziness, ringing, pain in ears
☐Tenderness or stiffness in the jaw, neck, or back
☐History of TMJ (jaw joint) problems
☐Taking birth control pills

DENTAL

☐Treated for or diagnosed with gum disease
☐Treated for or consulted for orthodontic therapy
☐Dental x-rays in the last year
☐Place a high priority on keeping natural teeth
☐Previous oral surgery
☐Tongue thrusting habit
☐Excessive fear of dental treatment
☐Brush your teeth (how often: _____)
☐Floss you teeth (how often: _____)
☐Bad breath or unpleasant taste in mouth
☐Bleeding gums/ Sore teeth
☐Gags easily
☐Tooth sensitivity
☐Fever blisters or mouth ulcers
☐Suck your thumb, finger, lip (now or in the past)

☐ Fish Oil
☐Aspirin
☐ Any other Vitamins, other than a multi-Vitamin, Please List:

Other Medical Problems or Concerns (Please state below):

The above information is accurate and complete to the best of my knowledge:

Patient Signature: _____ Date: _____ Dr.'s Initials: _____

If Minor, Parent or Guardian Signature: _____Date: _____ Dr.'s Initials: _____