Lefkoff
PERIODONTICS
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Medical History Form

Although dental personnel treat in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you in good health? .... ❑ Yes ❑ No
Has there been any change in your general health within the past year? .... ❑ Yes ❑ No
My last physical examination was on ....
Are you now under the care of a physician? .... ❑ Yes ❑ No
If Yes, what is the condition being treated? ....
The name and address of my physician is ....
....
Have you had any serious illness, operation, or been hospitalized in the past 5 years? .... ❑ Yes ❑ No
If so, what was the illness or problem? ....
Are you taking any medicine(s)? Please include prescription medications, vitamins, herbal supplements and over-the-counter medications. .... ❑ Yes ❑ No
If so, what medicine(s) are you taking?
....
....
....
....
Do you take aspirin daily? .... ❑ Yes ❑ No
Do you have a medical condition that requires you to take antibiotics before dental appointments? .... ❑ Yes ❑ No

Do you have or have you had any of the following diseases or problems?

Do you have artificial heart valves, a history of ineffective endocarditis, or congestive heart failure? .....❑ Yes ❑ No
Cardiovascular disease (heart trouble, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ....❑ Yes ❑ No
Surgery to replace joints or surgery that resulted in pins or plates being placed in your body ....❑ Yes ❑ No
Do you have chest pain upon exertion? ....❑ Yes ❑ No
Are you ever short of breath after mild exercise or when lying down? ....❑ Yes ❑ No
Do your ankles swell? ....❑ Yes ❑ No
Were you born with heart defects? ....❑ Yes ❑ No
Do you have a cardiac pacemaker? ....❑ Yes ❑ No
Allergies ....❑ Yes ❑ No
Sinus trouble ....❑ Yes ❑ No
Asthma or hay fever ....❑ Yes ❑ No
Fainting spells or seizures ....❑ Yes ❑ No
Persistent diarrhea or recent weight loss ....❑ Yes ❑ No
Diabetes ....❑ Yes ❑ No

Hepatitis, jaundice or liver disease ....❑ Yes ❑ No
AIDS or HIV infection ....❑ Yes ❑ No
Thyroid problems ....❑ Yes ❑ No
Respiratory problems, emphysema, bronchitis ....❑ Yes ❑ No
Arthritis or painful swollen joints ....❑ Yes ❑ No
Stomach ulcer, hyperacidity, GERD or reflux ....❑ Yes ❑ No
Kidney trouble ....❑ Yes ❑ No
Tuberculosis .....❑ Yes ❑ No
Persistent cough or cough that produces blood ....❑ Yes ❑ No
Persistent swollen glands in neck ....❑ Yes ❑ No
Low blood pressure ....❑ Yes ❑ No
Sexually transmitted disease ....❑ Yes ❑ No
Epilepsy or other neurological disease ....❑ Yes ❑ No
Depression and/or anxiety ....❑ Yes ❑ No
Cancer—Chemotherapy and/or radiation of the head and neck ....❑ Yes ❑ No
Problems of the immune system ....❑ Yes ❑ No

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Have you had abnormal bleeding? .... ☐ Yes ☐ No
Have you ever required a blood transfusion? .... ☐ Yes ☐ No
Do you have any blood disorder such as anemia? .... ☐ Yes ☐ No
Have you ever had any treatment for a tumor or growth? .... ☐ Yes ☐ No

Are you allergic or have you had a reaction to:

Local anesthetics ....☐ Yes ☐ No
Penicillin or other antibiotics ....☐ Yes ☐ No
Sulfa drugs ....☐ Yes ☐ No
Barbiturates, sedatives, or sleeping pills ....☐ Yes ☐ No
Aspirin ....☐ Yes ☐ No
Iodine ....☐ Yes ☐ No
Codeine or other narcotics ....☐ Yes ☐ No
Latex ....☐ Yes ☐ No
Metals ....☐ Yes ☐ No
Acrylic ....☐ Yes ☐ No

Foods: ....☐ Yes ☐ No
Specify: ....
....
....

Other ....☐ Yes ☐ No
Specify: ....
....
....

Have you had any serious trouble associated with any previous dental treatment? .... ☐ Yes ☐ No
If so, explain..
....
....

Do you have popping, clicking, and/or pain of your jaw joint? .... ☐ Yes ☐ No
Do you have any disease, condition, or problem not listed above
that you think I should know about? .... ☐ Yes ☐ No
If so, explain..
....

Are you wearing contact lenses? .... ☐ Yes ☐ No
Are you wearing removable dental appliances? .... ☐ Yes ☐ No
Do you use tobacco products? .... ☐ Yes ☐ No
If so, what type, and how frequently?...
Do you drink alcoholic beverages? .... ☐ Yes ☐ No
If so, what type, and how frequently?...

Women:

Are you pregnant? .... ☐ Yes ☐ No
Do you have any problems associated with your menstrual period? .... ☐ Yes ☐ No
Are you nursing? .... ☐ Yes ☐ No
Are you taking birth control pills? .... ☐ Yes ☐ No

Chief Dental Complaint:

....
....

I certify that I have read and understand the above questions. I have answered them as truthfully and thoroughly as possible. I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____ ____________

Signature of Patient Date

____ ____________

Signature of Dentist Date