Premier Periodontics & Implant Dentistry – MEDICAL HISTORY FORM

First Name: _____ MI: _____ Last: _____ Date_____

Primary Care Physician: _____Physician Phone: _____

Date of Most Recent Visit: _____ Are you in good health overall? ❑ YES ❑ No Age_____

Check any of the of the following that apply:

Heart & Blood:
❑ Heart Attack / Failure
❑ Heart Murmur
❑ Heart Pace Maker
❑ Irregular Heartbeat
❑ Congenital Heart Disorder
❑ Heart Valve Surgery
❑ Angina / Chest Pain
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Hemophilia
❑ Bruise Easily
❑ Blood Transfusion
❑ Anemia
❑ Excessive Bleeding
❑ Other Blood Disease
❑ Hypoglycemia
❑ Sickle Cell Disease
❑ Stroke

Internal Medicine:
❑ Diabetes
❑ Hepatitis
❑ Kidney Problems
❑ Stomach/Intestine Problems
❑ Ulcers
❑ Jaundice
❑ Liver Disease
❑ Renal Dialysis / Disease
❑ Recent Weight Gain / Loss

Autoimmune & Allergy:
❑ Arthritis / Gout
❑ Anaphylaxis /Severe
❑ Allergies
❑ Seasonal Allergies
❑ Hives / Rash
❑ Rheumatism
❑ AIDS / HIV
❑ Lupus

Lungs:
❑ Asthma
❑ Emphysema
❑ COPD
❑ Tuberculosis
❑ Frequent Cough

Cancer:
❑ Chemotherapy
❑ Radiation Treatment
❑ Leukemia
❑ Tumors or Growths
❑ Other Cancer

Surgeries:
❑ Artificial Joint Replaced
❑ Other Surgery

Other:
❑ Alzheimer's Disease
❑ Asthma
❑ Bisphosphonate Meds (Fosamax or Actonel)
❑ Cold Sores
❑ Convulsion / Seizure
❑ Drug Addiction
❑ Fainting / Dizziness
❑ Frequent Headache
❑ Glaucoma
❑ Herpes
❑ Osteoporosis
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Shingles
❑ Sinus Problems
❑ Spina Bifida
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tonsillitis
❑ Transplant Operation

Any illness or Surgery not listed above: _____

❑ Tobacco or smoking? ❑ E-cigarettes or Vapor? ❑ Alcohol? ❑ Recreational Drugs?

List type, history, and frequency for any of the above: _____

Allergies: ❑ Penicillin ❑ Local Anesthetic ❑ Aspirin ❑ Ibuprofen ❑ Tylenol ❑ Codeine ❑ Latex ❑ Foods ❑ Metal ❑ Others

Allergy Details for any of the above: _____

WOMEN ONLY: ❑ Pregnant / Due Date _____ ❑ Trying to get Pregnant ❑ Breastfeeding/nursing ❑ Birth Control Pills

Medications, including nonprescription drugs, vitamins, and herbals (name, dose, reason for taking):

_____

_____

_____

_____

(if you need to list more, please give list to our office staff to copy, or use the back of this sheet)

❑ A doctor told me to take antibiotics before getting dental treatment _____

Anything else we should know about your medical history: _____

I certify that to the best of my ability this form has been completed to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____