MEDICAL / DENTAL HISTORY FORM

AURORA Periodontics and IMPLANT DENTISTRY

Patient Name_____ Date of Birth_____Today's Date_____

Your answers are for our records only and will be considered confidential.

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

Heart disease / heart attack	NO	YES	Diabetes	NO	YES
Artificial heart valve/ congenital heart defect	NO	YES	Osteoporosis	NO	YES
Pacemaker	NO	YES	Radiation or chemotherapy	NO	YES
High or low blood pressure	NO	YES	Bone cancer or bone disease	NO	YES
Chest pains or angina	NO	YES	Sinus problems	NO	YES
Stroke	NO	YES	Kidney disease	NO	YES
Artificial joint	NO	YES	Asthma	NO	YES
Excessive or prolonged bleeding	NO	YES	Arthritis	NO	YES
HIV or other immunosupressive disease	NO	YES	Tuberculosis (TB)	NO	YES
Hepatitis / Liver disease	NO	YES			

Do you have, or have you had any disease, condition or problem not listed above? NO YES

If yes, Please explain:

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, local anesthetic or any drugs or medications? NO YES

Do you currently smoke or use tobacco? NO YES

Have you ever smoked or used tobacco? NO YES

Have you ever been told to take antibiotics or to premedicate prior to dental appointments? NO YES

Do you use recreational drugs? NO YES

Have you been a patient in the hospital during the past five years? NO YES

Have you been under the care of a medical doctor during the past two years? NO YES

Are you currently under the care of a physician(s)? NO YES

When were you last seen by a physician?_____

Name of physician_____

Street Address_____

Phone_____

Women only:

Are you nursing or pregnant? NO YES

Are you taking birth control pills? NO YES

OVER →

LIST OF MEDICATIONS - taken within the last 2 years

DRUG NAME	DOSE / FREQUENCY	REASON FOR TAKING	CURRENTLY TAKING
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N

Are you taking any over the counter medications (ie Aspirin, Tylenol, Ibuprofen) or herbal medications? NO YES
If yes, Please list above

Have you taken any steroid medications (ie prednisone) in the past two years NO YES

Have you ever taken any oral or IV bisphosphantes (for treatment of osteoporosis or bone cancer) such as Fosamax (alendronate), Actonel (risedronate), Atelvia, Boniva (ibandronate), Reclast, Zometa, Didronel, Aclasta, Aredia, or Skelid? NO YES

Please sign below to attest that the information provided is complete and correct.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

DENTAL HISTORY

What is the reason for your visit to the periodontist? Please describe below.

Are you having pain or discomfort at this time? NO YES

Do you feel nervous about dental treatment or have you ever had a bad experience in a dental office? NO YES

Prior to your most recent visit, please estimate the last time you visited the dentist._____

Have you ever had a deep cleaning (scaling and root planing)? NO YES

If yes, please list when _____

When was your last cleaning? _____

Have you ever been treated for periodontal (gum) disease in the past? NO YES

(a) Do you remember what treatment you had? If so, please describe.

(b) How long ago did you receive this/these treatment(s)?_____

Has anyone else in your family been diagnosed with periodontal (gum) disease? NO YES

Do you have any other concerns you wish to speak about? NO YES
If so, please describe.