Lorenzana Periodontics

Medical History Form

INITIALS: _____

PATIENT NAME: _____ BIRTH DATE: _____ DATE CREATED: _____

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

Are you currently under a physician's care?	O Yes O No
If YES:	
Have you ever been hospitalized or had a major operation?	O Yes O No
If YES:	
Have you ever had a serious head or neck injury?	O Yes O No
If YES:	
Are you taking any medications, pills, or drugs?	O Yes O No
If YES:	
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No
If YES:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No
If YES:	
Are you on a special diet?	O Yes O No
If YES:	
Do you use tobacco? How long? How much?	O Yes O No
If YES:	
Do you use controlled substances?	O Yes O No
If YES:	
Are you diabetic? Latest HbA1c?	O Yes O No
If YES:	
Family history of diabetes?	O Yes O No
If YES:	

WOMEN: Are you…		
□ Pregnant/Trying to get pregnant?	□ Nursing?	□Taking oral contraceptives?

Are you ALLERGIC (rash, hives, swollen throat, anaphylaxis) to any of the following?			
□ Aspirin	□ Penicillin	□ Codeine	□ Acrylic
□ Metal	□ Latex	□ Sulfa drugs	□ Local anesthetics
□ Food allergy	□ Other? O Yes O No If YES:		

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Do you have or have you had any of the following? (Circle Y or N for each)					
AIDS/HIV Positive	Y / N	Excessive Bleeding	Y / N	Lung Disease (inc. COVID)	Y / N
Alzheimer's Disease	Y / N	Excessive Thirst	Y / N	Mitral Valve Prolapse	Y / N
Anaphylaxis	Y / N	Fainting Spells/Dizziness	Y / N	Osteoporosis	Y / N
Anemia	Y / N	Frequent Cough	Y / N	Pain in Jaw Joints	Y / N
Angina	Y / N	Frequent Diarrhea	Y / N	Parathyroid Disease	Y / N
Arthritis/Gout	Y / N	Frequent Headaches	Y / N	Psychiatric Care	Y / N
Artificial Heart Valve	Y / N	Genital Herpes	Y / N	Radiation Treatments	Y / N
Artificial Joint	Y / N	Glaucoma	Y / N	Recent Weight Loss	Y / N
Asthma	Y / N	Hay Fever	Y / N	Renal Dialysis	Y / N
Blood Disease	Y / N	Heart Attack/Failure	Y / N	Rheumatic Fever	Y / N
Blood Transfusion	Y / N	Heart Murmur	Y / N	Rheumatism	Y / N
Breathing Problems	Y / N	Heart Pacemaker	Y / N	Scarlet Fever	Y / N
Bruise Easily	Y / N	Heart Trouble/ Disease	Y / N	Shingles	Y / N
Cancer	Y / N	Hemophilia	Y / N	Sickle Cell Disease	Y / N
Chemotherapy	Y / N	Hepatitis A	Y / N	Sinus Trouble	Y / N
Chest Pains	Y / N	Hepatitis B or C	Y / N	Spina Bifida	Y / N
Cold sores/Fever Blisters	Y / N	Herpes	Y / N	Stomach/Intestinal Disease	Y / N
Congenital Heart Disorder	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
Convulsions	Y / N	High Cholesterol	Y / N	Swelling of Limbs	Y / N
Yellow Jaundice	Y / N	Hives or Rash	Y / N	Thyroid Disease	Y / N
Cortisone Medicine	Y / N	Hypoglycemia	Y / N	Tonsilitis	Y / N
Diabetes	Y / N	Irregular Heartbeat	Y / N	Tuberculosis	Y / N
Drug Addiction	Y / N	Kidney Problems	Y / N	Tumors or Growths	Y / N
Easily Winded	Y / N	Leukemia	Y / N	Ulcers	Y / N
Emphysema	Y / N	Liver Disease	Y / N	Venereal Disease	Y / N
Epilepsy or Seizures	Y / N	Low Blood Pressure	Y / N		

Have you ever had any serious illness not listed above? Y / N If yes: _____

_____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: X _____ **Date:** _____