PATIENT MEDICAL HISTORY

Name ______________________________ Date ______________

Patient's Physician ______________________________ Date of Last Physical ______________

Physician's Address ________________ City ____________ State ______ Zip ______ Phone ____________

Do you have or have you ever had (✓ if yes):

_____ Anemia
_____ Artificial joint replacement
_____ A.I.D.S.
_____ Arthritis
_____ A stroke
_____ Any blood disorders
_____ Asthma
_____ Bleeding problems
_____ Cancer
_____ Congenital heart problem
_____ Diabetes
_____ Drug allergies (please list)
____
____
_____ Epilepsy
_____ Heart trouble (please describe)
____
_____ Heart murmur
_____ Hepatitis
_____ Hemophilia
_____ High blood pressure
_____ H.I.V. positive
_____ Kidney trouble
_____ Liver trouble
_____ Lung disease
_____ Psychiatric treatment
_____ Rheumatic fever
_____ Radiation therapy
_____ Tuberculosis
_____ Ulcers
_____ Venereal disease

Are you (✓ if yes):

_____ being treated for any illness
_____ a smoker
_____ a user of smokeless tobacco
_____ a user of alcohol
_____ taking or have taken cortisone
_____ taking aspirin daily
_____ taking any medications (please list):
____
____
____

Do you have any disease or health problems not listed above? Yes ____ No _____(please describe):

____

Women: Are you (✓ if yes): ______ pregnant ______ nursing ______taking birth control pills

PATIENT DENTAL HISTORY

Do you have or have you ever had (✓ if yes):

_____ A reaction to an anesthetic
_____ Bad breath
_____ Bleeding gums
_____ Difficulty in chewing
_____ Grinding or clenching of teeth
____ Jaw popping or jaw pain
____ Loose teeth
____ Previous periodontal treatment
____ Teeth sensitive to hot, cold, or sweets

Why did you make this appointment? ______________________________
Date of last dental appointment? ________________ Who is your dentist? ________________
How many times have you had your teeth cleaned in the last 3 years? _____ When was the last time? _________
Are you satisfied with the appearance of your teeth? yes ____ no ____
Are you apprehensive about dental treatment? yes ____ no ____

I hereby grant permission to Dr. Kohlhorst and his staff for the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The medical and dental information answered on this form is correct to the best of my knowledge. I will notify this office if there are any changes in my Medical or Dental History.

______________________________ ______________________________
Patient, Parent or Legal Guardian Date Periodontist/Staff Date