PRISTINE PERIODONTICS AND IMPLANTS
A. SAYED, DDS, MS
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MEDICAL HISTORY

Patient Name_____Nickname_____ Age_____Weight_____

Name of Physician/and their specialty_____

Most recent physical examination _____Purpose _____

	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic reaction to		
☐aspirin, ibuprofen, acetaminophen, codeine ☐penicillin		
☐erythromycin ☐tetracycline ☐sulfa ☐local anesthetic ☐fluoride		
☐metals (nickel, gold, silver, _____)		
☐latex ☐other _____		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. artificial prosthesis (heart valve or joints)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. emphysema, sarcoidosis	☐	☐
14.tuberculosis	☐	☐
15.asthma	☐	☐
16. breathing or sleep problems	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19.jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c =___)	☐	☐
2n. stomach or duodenal ulcer	☐	☐
2p. digestive disorders (i.e. gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐

	YES	NO
27. arthritis	☐	☐
28. glaucoma	☐	☐
29. contact lenses	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsions (seizures	☐	☐
32. neurologic problems (attention deficit disorder)	☐	☐
33. viral infections and cold sores	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. venereal disease	☐	☐
37. hepatitis (type__)	☐	☐
38. HIV / AIDS	☐	☐
39. tumor, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy	☐	☐
42. emotional problems	☐	☐
43. psychiatric treatment	☐	☐
44. antidepressant medication	☐	☐
45. alcohol / drug dependency	☐	☐
ARE YOU:		
46. presently being treated for any other illness	☐	☐
47. aware of a change in your general health	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements	☐	☐
50. often exhausted or fatigued	☐	☐
51. subject to frequent headaches	☐	☐
52. a smoker or smoked previously	☐	☐
53. considered a touchy person	☐	☐
54. often unhappy or depressed	☐	☐
55. FEMALE - taking birth control pills	☐	☐
56. FEMALE – pregnant	☐	☐
57. MALE - prostate disorders	☐	☐

Have you ever been advised to pre-medicate for dental treatment? If so, what for?

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug _____Purpose_____ Drug _____Purpose_____

Drug _____Purpose_____ Drug _____Purpose_____

Drug _____Purpose_____ Drug _____Purpose_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature_____Date_____

Doctor's Signature _____Date _____

Send completed form to: frontdesk@pristineperioimplants.com