PRISTINE PERIODONTICS AND IMPLANTS | A. SAYED, DDS, MS

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 =___)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. 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 **Submit Form** **Print Form**