Wilmington Periodontics & Implant Center

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Name: **MEDICAL HISTORY** Date:

Are you presently or have you been under the care of a physician during the past 5 years? *

Have you ever been hospitalized or had any operations? *

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

☐ Alg-Adhesive Tape	☐ Alg-DentalAnesthetic	☐ Allergy-Medication	☐ Asthma
☐ Bleeding Problems	☐ Blood Disorder	☐ BloodTransfusion	☐ Chronic Cough
☐ Convulsions	☐ Current Birth Contr.	☐ Diabetes Type 1	☐ Diabetes Type 2
☐ Dizziness	☐ Emphysema	☐ Epilepsy	☐ Glaucoma
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV/AIDS	☐ Hormone Medications	☐ Joint Replacement	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ Pregnancy	☐ PreMed	☐ Rheumatic Fever
☐ Shortness of Breath	☐ Sickle Cell Anemia	☐ Sleep Apnea	☐ Steroid Treatment
☐ Stroke	☐ Thyroid Trouble	☐ Tobacco User	☐ Tuberculosis
☐ Ulcers			

If "yes" to any of the above please provide details (year diagnosed, complications, follow up)

Are you taking any prescription or non prescription drugs, medicines, or pills or any kind? If yes please list below

Have you ever been told you had or have heart problems, a heart murmur, or rheumatic fever? *

Are you allergic to any medications, drugs, dental anesthetics, or adhesive tape? *

Have you ever had any bleeding problems, blood disorders, or a blood transfusion?

Have you ever had or are you subject to dizziness, nervous disorders, convulsions, or epilepsy? *

Have you ever had any breathing or lung problems? *

If female, are you pregnant, taking birth control of any type, or taking hormone medications?

Have you ever been prescribed a bisphosphonte (oral or injection)? *

Have you ever had steroid treatments? *

Are you now, or have you ever been a smoker or used tobacco products? *

Do you currently Drink Alcohol? *

Do you now or have you ever used any illicit drugs?

I agree to notifiy the office of any changes to my health status or medications, ◯ Yes ◯ No

Any addtional information concerning my overall health or questions for the Doctor may be added here.

Thank you for taking the time to complete the above information. The knowledge of this information enables a more thoroughly diagnosis as we strive to treat you to the best of our abilities. We appreciate your openness but respect your privacy, all information and testing will be held in the strictest of confidence.

Signature: **Response Date:** ____/____/________