Wilmington Periodontics & Implant Center

www.wilimingtonimplantcenter.com

1611 Doctor's Circle • Wilmington, NC 28401 (910)772-9770

Name:

MEDICAL HISTORY

Who is your primary care provider? (Please list office location.) Please include any additional providers you routinely see.

Preferred pharmacy and location:

List any hospitalizations or operations and the year of occurrence. Were there any complications during any procedures?

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

☐ Asthma	☐ Bleeding Problems	☐ Blood Disorder	☐ Blood Transfusion
☐ Chronic Cough	☐ Convulsions	☐ Current Birth Contr.	☐ Diabetes Type 1 - Last A1C:
☐ Diabetes Type 2 - Last A1C:	☐ Dizziness	☐ Emphysema	☐ Epilepsy
☐ Glaucoma	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/AIDS	☐ Hormone Medications
☐ Joint Replacement	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Nervous Disorders	☐ Other-Please Specify	☐ 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, any complications, follow up):

List all medications, supplements, or vitamins that you take with the associated dose and frequency:

Do you have a family history of cancer, heart disease, and/or diabetes? If yes, please list which apply, and to whom (grandparents, parents, or siblings):

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

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

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?

Have you ever been prescribed a bisphosphonate (oral or injection)? If yes, please provide type, frequency, and dose.

Have you ever had steroid treatments? If yes, when was the treatment and why were you treated?

Are you now, or have you ever been a smoker or used tobacco products? Please list how many years you have smoked and the number of packs per day?

Do you currently drink alcohol? If yes, how much and how frequently?

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 additional 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.

Response Date: ___________