Wilmington Periodontics & Implant Center

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

Name & Date of Birth:

Names & locations of physician and/or primary care provider and any other healthcare provider?

Preferred pharmacy (name, address, phone/fax):

List all hospitalizations and operations, including child birth, year of occurrence, and any complications.

Do you have or have you ever had any of the following:

☐ Diabetes Type 2	☐ Diabetes Type 1	☐ Glaucoma	☐ High Blood Pressure
☐ Joint Replacement	☐ Sleep Apnea	☐ Bleeding Problems	☐ High Cholesterol
☐ Kidney Disease	☐ Tuberculosis	☐ Blood Disorder	☐ HIV/AIDS
☐ Liver Disease	☐ Shortness of Breath	☐ Stroke	☐ Ulcers
☐ Blood Transfusion	☐ Hepatitis	☐ Horomone Medications	☐ Low Blood Pressure
☐ Sickle Cell Anemia	☐ Thyroid Trouble	☐ Gastrointestinal Issues	☐ Steroid Treatment

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 regularly or as needed with the dose and frequency:

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

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

Have you ever had heart surgery, heart problems, a heart murmur, rheumatic fever, a pacemaker or stents placed?

Have you ever been told to pre-medicate with antibiotics prior to a dental visit? Why do you pre-medicate?

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

Have you ever had any breathing or lung problems such as asthma, COPD, chronic cough, or emphysema?

Have you ever been told you have osteoporosis or osteopenia, and have you ever taken drugs such as bisphosphonates or other bone sparing drugs for these, or any other condition?

If female, are you pregnant, possibly pregnant or taking birth control medication for any reason?

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

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

Do you, or have you ever, used illicit drugs?

Is there any additional information concerning your overall health not asked above or of which the d

☐ **By checking this box, I agree to notify the office of any changes to my health status or medications.**

Thank you for taking the time to complete the above information. The knowledge of this information enables a more thorough 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 (Patient or Guardian):

Response Date: