The Perioclinic
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Diplomates of the American Board of Periodontology

This will become part of your office record and will be held in strict confidence.

MEDICAL HISTORY

PATIENT NAME _________________________________ TODAY'S DATE _________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS OR DISORDERS

High blood pressure	Yes	No
Low blood pressure	Yes	No
Heart murmur or mitral valve prolapse	Yes	No
Any type of heart condition/attack/surgery	Yes	No
If yes, describe _____________________		
Prolonged or excessive bleeding	Yes	No
Easy bruising	Yes	No
Anemia	Yes	No
Other blood or circulation problems	Yes	No
Artificial joints	Yes	No
Have you ever had a reaction or allergy to any drugs, pills, anesthetics, or medicines?	Yes	No
Which ones? _____________________		
Explain the reaction __________________		
Drug abuse	Yes	No
Treatment for drug abuse or alcoholism	Yes	No
Treatment for an emotional disorder	Yes	No
Diabetes	Yes	No
History of diabetes in family	Yes	No
Hepatitis, jaundice or other liver diseases	Yes	No
Stomach trouble, colitis, or ulcers	Yes	No
Fainting spells, dizziness, or seizures	Yes	No
Sinus problems	Yes	No
AIDS or HIV	Yes	No
Immunological problems	Yes	No
Arthritis, rheumatism, or other joint problems	Yes	No
Respiratory problems, emphysema, bronchitis.	Yes	No
Tuberculosis	Yes	No
Kidney or bladder problems or infections	Yes	No
Asthma	Yes	No
Sexually transmitted diseases	Yes	No
Thyroid problems	Yes	No
Do you consider yourself a nervous person	Yes	No
Are you under high stress	Yes	No
Glaucoma or other eye diseases	Yes	No
Do you wear contact lenses	Yes	No
Skin lesions or diseases	Yes	No
Treatment for any tumors, growths, or cancer	Yes	No
Explain __________________________		

Do you smoke? __________ How much _______
For how long ____________
Did you ever smoke? ________ How much _______
When did you stop smoking? _________________

Are you under a physician's care now?	Yes	No
In the past 2 years?	Yes	No
Have you been hospitalized in the past 5 yrs.?	Yes	No
if yes, for what? ________________________		

Date of last physical exam or checkup: _______________
Findings ____
How would you rate your health?
□ Good □ Fair □ Poor □ Don't Know
What pills drugs or medicines do you take on a regular basis (prescribed or over the counter, including vitamins or aspirin)
____
____
____

What have you taken in the past that has worked well for
pain ____
infection ______________________________________

Do you eat a balanced diet? Yes No
How many alcoholic beverages do you have in a day? _____
in a week? ________

WOMEN:

Are you pregnant? ______ If yes, how many months ______

Are you trying to become pregnant?	Yes	No
Are you going through or completed menopause?	Yes	No
Are you now taking birth control pills?	Yes	No
Do you know that antibiotics may cause birth control to be ineffective?	Yes	No

Is there anything else or anything special you think I should know about your medical history? ____

I certify that I have answered all questions to the best of my knowledge. I will not hold Dr. Nasr, Dr. Sáenz, or their staff responsible for any errors that I may have made in the completion of this form.

Patient signature ______________________________________ Doctor signature ____

Medical history update:
Date _____________________ Comments ____
Date _____________________ Comments ____
Date _____________________ Comments ____