

# MEDICAL & DENTAL HISTORY

PERIODONTAL CARE- David J. Thein, DDS, MSD    Daniel Shin, DDS, MSD

The reason for your visit today?: \_\_\_\_\_  
\_\_\_\_\_

1. Do you use tobacco products?    YES    NO    How much? \_\_\_\_\_    For how long? \_\_\_\_\_

2. Have you ever been hospitalized overnight for any reason?    YES    NO

If YES, why? \_\_\_\_\_

3. Do you have any prosthetic devices (e.g. heart valve or stent, artificial joint, implant, pacemaker, etc.)?    YES    NO

4. Are you currently taking any medicine, pills or drugs, either prescription or over-the-counter?    YES    NO

If YES, what? \_\_\_\_\_  
\_\_\_\_\_

5. Are you allergic or sensitive to any medicine, dental anesthetic or latex products?    YES    NO

If YES, to what? \_\_\_\_\_

6. Do you have now ***or have you ever had*** any of the following diseases or medical conditions? (please circle if YES)

- CARDIOVASCULAR SYSTEM**  
Heart Disease / Heart Attack / MI  
Congestive Heart Failure  
Coronary Artery Disease / Bypass  
Heart Surgery / Angioplasty / Stent  
Pacemaker  
Congenital Heart Defect  
Heart Murmur  
Mitral Valve Prolapse  
Rheumatic Fever  
High Blood Pressure  
Stroke / TIA  
Fainting / Dizziness  
Hemophilia / Prolonged Bleeding  
Chest Pain / Angina Pectoris  
Palpitations / Arrhythmia  
Shortness of Breath  
Chronic Tiredness / Fatigue  
Blood Transfusion  
Aneurysm

- RESPIRATORY SYSTEM**  
Emphysema  
Chronic Bronchitis  
Tuberculosis (TB)  
Asthma  
Wheezing / Difficulty Breathing  
Persistent Cough  
Allergies / Hives  
Sinus Problems  
Difficult to Lie Back in Dental Chair

- NEUROLOGICAL SYSTEM**  
Seizures / Epilepsy / Convulsions  
Eye / Vision Disorders  
Hearing Loss / Ear Problems  
Severe Headaches / Dizziness  
Weakness / Tingling / Numbness  
Psychiatric Treatment / Depression  
Panic Attacks / Phobias  
High Fear of Dentistry

- GI-GU SYSTEM**  
Hepatitis A, B or C / Liver Disease  
Recent Weight Gain or Loss  
Cholitis / Crohn's / Intestinal Problem  
Kidney, Bladder Problems / Dialysis  
Sexually Transmitted Disease  
Diabetes / High Blood Sugar  
↑ Urination / ↑ Thirst  
On a Special Diet

- OTHER SYSTEMS**  
Drug Addiction / Dependency  
Alcoholism / Dependency  
Cancer / Malignancies  
Chemo / Radiation Therapy  
HIV+ / AIDS  
Thyroid Problems  
Arthritis / Gout / Lupus  
Organ Transplant  
Women: currently pregnant

7. Is there any additional information (disease, condition or problem not listed above) we should know about?    YES    NO

If YES, explain: \_\_\_\_\_

8. Are you currently under a doctor's care?    YES    NO    If YES, for what? \_\_\_\_\_

***To the best of my knowledge, the information I have given today is true and correct. I understand that this information will be held in confidence and it is my responsibility to inform this office of any future changes in my medical status. Should further information be needed, you have my permission to consult with other health care providers or agencies, who may release any such information or x-rays to you. Additionally, I authorize you to release any of my records and/or x-rays and correspond with other health care providers or agencies as you deem necessary during the course of my care. I also give you permission to take clinical photographs as needed.***

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date