Annapolis Periodontics

practice limited to periodontics and implant dentistry

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Patient Name:_____ Date:_____

Physician Name:_____Phone ( )_____
Date of last medical exam:_____
Are you now or have you been under a physicians care? YES NO
Have you been hospitalized or had a serious illness? Please explain:_____
Have you ever had to pre-medicate prior to a dental appointment?_____

Have you ever had or currently have the following conditions:

__ Abnormal Bleeding
__ Alcohol Abuse
__ Allergies
__ Anemia
__ Arthritis
__ Asthma
__ Blood Transfusion/Disease
__ Cancer- Chemotherapy
__ Diabetes
__ Emphysema
__ Epilepsy
__ Fainting Spells
__ Glaucoma
__ Hay Fever
__ HIV + AIDS
__ Heart Problems
__ Heart Murmur/ MVP
__ Heart Valve Replacement
__ Hepatitis
__ High Blood Pressure
__ Joint Replacement
__ Kidney/ Bladder Problems
__ Liver Disease
__ Low Blood Pressure
__ Lung Disease
__ Pace Maker
__ Prolonged Bleeding
__ Psychiatric Problems
__ Radiation Therapy
__ Rheumatic Fever
__ Shortness of Breath
__ Sickle Cell Disease
__ Sinus Problems
__ Thyroid Problems
__ Tuberculosis
__ Ulcers
__ Unable to Give Blood
__Venereal Disease
__ Other_____
_____

Are you taking any medication on a routine basis? (over the counter medication, birth control, shots, implant, hormone therapy, etc.) Please list:_____
_____
Do you smoke or use tobacco? YES NO If yes, how much?_____

Check any of the following that you are taking or have taken:

__Cortisone Drugs
__Steroids
__Anticoagulants
__Blood Thinners
__Tranquilizers
__Sedatives
__Fosamax
__Bisphosphonates

Are you allergic to or do you suffer ill effects from any of the following?

__Penicillin
__Aspirin
__Metals
__Codeine
__Household Bleach
__Other_____
__Dental Anesthesia
__Latex Products

If female, please answer the following:
Are you pregnant? __ Y or __ N If yes, how many months?_____ Are you breast feeding?_____

The above information is true to the best of my knowledge.

Signature_____ Date _____