PERIODONTICS & IMPLANTOLOGY
PERIODONTICS OF GREENVILLE

Patient Information

Name:_______________________________________ Gender: M / F DOB:_____________ Age: _________

Phone #:___________________________ Height (ft): _______________ Weight (lbs):_____________ BMI (staff complete):_______

Surgical and Anesthesia History

Have you ever had surgery before? .... Y / N

Please list____

Have you ever had anesthesia before? .... Y / N

If yes, did you have any complications from anesthesia that you know of? (list:) ____

Has anyone else in your family had aa problem with anesthesia? .... Y / N

Medical History

General practitioner's name:____________________________________ Phone #:_______________________ Last Visit: ___________

Do you see any other doctors/ specialty providers?.. Y / N

If yes, Who and why?____

Do you see any doctors for pain management?.. Y / N

If yes, Who and why?____

Have you ever been hospitalized for any illness or surgical operation? .... Y / N

If yes, When and Why?____

Have you ever been told to take an antibiotic before going to the dentist? .... Y / N

If yes, Why and What?____

Allergies

List any allergies and reactions:____

Allergic to latex.. Y / N

Medications & supplements (please list **ALL** medications and supplements, including doses and frequency)

☐ **None**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Bone/osteoporosis: (circle one)

Fosamax Boniva Zometa Aredia Didronel Reclast Prolia Xgeva

Other (list): ____

When was your last injection? _____________________ **or N/A** How many injections have you had? ________________

Please initial below once you have reviewed this document:

Periodontist ___________ **Dental Assistant** ___________ **Treatment Coordinator** ___________

Heart / Cardiovascular	Lungs / Respiratory
High blood pressure........ Y / N	Asthma........ Y / N
Heart attack / MI........ Y / N	Inhaler........ Y / N
Heart disease........ Y / N	COPD........ Y / N
Valve problems........ Y / N	Emphysema........ Y / N
Valve replacement........ Y / N	Do you snore........ Y / N
Pacemaker or defibrillator........ Y / N	Sleep Apnea...(Central or Obstructive)........ Y / N
Chest pain / angina / palpitations........ Y / N	CPAP........ Y / N
Recently lost / gained weight without trying........ Y / N	Chronic cough........ Y / N
Shortness of breath........ Y / N	Recent cold or flu........ Y / N
Heart failure........ Y / N	Recent travel out of the country........ Y / N
Rheumatic Fever........ Y / N	Cigarette / cigars / smokeless / vaping........ Y / N
Heart infection / endocarditis........ Y / N	How much? _____ packs per day….. How long? _____ years
Peripheral Vascular Disease........ Y / N	History of tuberculosis (TB)........ Y / N
Other? Please list: ________________	Pulmonary hypertension........ Y / N
	Difficulty breathing?........ Y / N
	Use oxygen at home?........ Y / N
	Other? Please list: ________________

Head / Neurology/Musculoskeletal	Stomach / Bowel / Kidney/ Lab values
Stroke........ Y / N	Acid reflux / heart burn / peptic ulcer disease........ Y / N
Seizures........ Y / N	Irritable Bowel Syndrome........ Y / N
Debilitating headaches........ Y / N	History of C-Diff........ Y / N
Contact lenses or glasses........ Y / N	Diabetes........ Y / N
Glaucoma........ Y / N	Do you use insulin........ Y / N
Fainting........ Y / N	Thyroid problems........ Y / N
Parkinson's........ Y / N	Prescribed steroids........ Y / N
Multiple Sclerosis........ Y / N	Kidney problems........ Y / N
Muscle disorders........ Y / N	Liver problems........ Y / N
Arthritis........ Y / N	Other? Please list: ________________
Joint Replacement........ Y / N	
Gout........ Y / N	
Peripheral neuropathy........ Y / N	
Other? Please list: ________________	

Blood Related / Infectious Disease	Miscellaneous
Blood disorder........ Y / N	How much alcohol per week________________ or N/A
Anemia........ Y / N	Use of recreational drugs........ Y / N
Cancer........ Y / N	Autoimmune disease........ Y / N
Type:________________	Type:________________
Radiation/Chemo (when):________________	Organ Transplant........ Y / N
Sickle cell disease or trait........ Y / N	Other? Please list: ________________
Infectious Disease (MRSA, VRE, etc.)........ Y / N	**WOMEN**
Hepatitis....Circle Type: A B C........ Y / N	Are you taking birth control / contraceptives........ Y / N
HIV or AIDs........ Y / N	Is there a chance you could be pregnant........ Y / N
Religious beliefs that affect your decisions about blood........ Y / N	Are you breastfeeding........ Y / N
Are you a blood donor........ Y / N	Other? Please list: ________________
Other? Please list: ________________	

Authorization and Release: I certify that I have read and understand the above information, and, to the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist too release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners.

Signature: ______________________________ Date: ____________________