IMPLANT&PERIO CENTER OF KANSAS

Marq J. Sams, DMD MS PA

Medical History

Patient Name:	Birth Date:	Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

General Single Questions	YES	NO	
What is the name and phone of your physician?	◯	◯	If yes:
What is the name and phone # of any specialist you see?	◯	◯	If yes:
Have you ever been hospitalized or had a major operation?	◯	◯	If yes:
Have you ever had a serious head or neck injury?	◯	◯	If yes:
Are you taking any medication, pills, or drugs?	◯	◯	If yes:
Have you ever taken bisphosphonate medications?	◯	◯	If yes:
Such as Fosamax/alendronate, Zometa/zolendronic acid, Boniva/ibandronate, Actonel/risedronate, etc?	◯	◯	If yes:
Do you smoke or chew tobacco?	◯	◯	If yes:

Women: Are you…

◯ Pregnant/Trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic

◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics

◯ Tetracycline

Other?	◯ Yes	◯ No	If yes:
Do you use controlled substances?			If yes:

See Other Side

Do you have, or have had, any of the following?

AIDS/HIV Positive	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Herpes	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Cortisone Medicine	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Easily Winded	◯ Yes	◯ No	Scarlet fever	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Epilepsy or Seizures	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Fainting Spells/Dizziness	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Frequent Diarrhea	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Frequent Headaches	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Genital Herpes	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Heart Attack/Failure	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Heart Pacemaker	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
Heart Trouble/Disease	◯ Yes	◯ No	Yellow Jaundice	◯ Yes	◯ No
Hemophilia	◯ Yes	◯ No			

Have you ever had and serious illness not listed above? ◯ Yes ◯ No | If yes:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X

Date: