# GENERAL HEALTH HISTORY

**NAME:** _____ **AGE:** _____ **D.O.B.** _____

**PLEASE LIST YOUR FAMILY PHYSICIAN AND ANY MEDICAL SPECIALISTS THAT YOU SEE AT LEAST ONCE A YEAR:**

**Name** **Address** **Phone #** **Specialty**

_____

_____

_____

**YES NO** **Are you in good general health?**

**YES NO** **Are you currently under a physician's care?**
**For:** _____

_____

**Please list all prescription or over-the-counter drugs that you are taking and why:**

_____

_____

_____

**Do you have (or have you ever had) any of the following?**

**YES NO** **Allergic reaction to drugs or latex (Circle all that apply)**
**Latex Penicillin Aspirin Codeine Local Anesthetics Other**_____

_____

**YES NO** **Do you currently take any of the following. (Circle all that apply)**
**Coumadin Pradaxa Warfarin Effient Eliquis**
**Plavix Xarelto Brilinta Daily Aspirin**

**YES NO** **Do you regularly take herbal medicines or dietary supplements?**
**Specifically, do you take any of the following (Circle all that apply)**
**Echinacea Garlic Ginger Kava Feverfew Gingko Ginseng St. John's Wort**
**Vitamin E Fish Oil**

**YES NO** **Have you undergone current or past osteoporosis therapy? (Circle all that apply)**
**Fosamax Actonel Boniva Reclast Prolia**
**If so, how long have you been on the medication?** _____

YES NO Have you undergone current or past therapy to reduce high blood calcium?
Bisphosphonate chemotherapy utilizing intravenous Aredia and Zometa

YES NO Heart attack or heart disease

YES NO High blood pressure

YES NO Artificial heart valve
YES NO Bacterial endocarditis
YES NO Any condition that requires antibiotic pre-medication before dental treatment
Specify_____

YES NO Artificial joints **(Circle all that apply)**
Hip Knee Ankle Shoulder
Dates placed:

YES NO Immunosuppressive condition **(Circle all that apply)**
Steroid Therapy (e.g. Prednisone) Radiation Therapy Cancer Therapy Lupus
Rheumatoid Arthritis HIV Organ Transplant Spleen Removed Other
YES NO Bleeding problem; anemia or other blood disease
YES NO Diabetes If so, is it controlled? YES NO
YES NO Thyroid disease
YES NO Asthma
YES NO Stomach Trouble
YES NO Hepatitis
YES NO Kidney disease
YES NO Liver disease
YES NO Mental Health condition - Specify _____
YES NO Do you have or have you ever been treated for cancer? – Specify _____
_____

YES NO Do you smoke? How much _____
YES NO Do you use smokeless tobacco?
How interested are you in stopping your tobacco use? (Circle one)
Very interested Somewhat interested Not at all interested
YES NO Do you drink alcohol? Occasionally Daily
YES NO Do you have any disease, condition or problem not listed here?

_____

_____

_____

_____

_____

_____

**WOMEN:**

YES NO Are you or could you be pregnant? If yes - What trimester? _____
YES NO Breast feeding?
YES NO Taking oral contraceptives?

**REMINDER: USE OF ANTIBIOTICS MAY CAUSE DECREASED EFFECTIVENESS OF ORAL CONTRACEPTIVES**

**Do you have (or have you ever had) any of the following?**

YES NO Dental pain
YES NO Bleeding Gums
YES NO Sores or Lumps in your mouth
YES NO Persistent Headaches or Earaches
YES NO Would you be distressed if you had to wear dentures?
YES NO Do you want to save your teeth?
YES NO Are you happy with the appearance of your teeth?
YES NO Are you allergic to any metals or dental materials?

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**Please circle the types of dental treatment you have experienced.**

Orthodontics (braces) Root canal treatment Oral surgery
TMJ treatment Periodontal (gum) Treatment Dental Implants
Crowns Bridges Dentures

## OFFICE POLICY AND TREATMENT CONSENT

*I hereby certify that the foregoing information is correct. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending periodontist or supervised staff for diagnostic purposes or dental treatment. I give permission for any insurance payments to be made directly to the providing periodontist. I give my permission to contact necessary professionals concerning my current health, past dental and medical treatment, and recommended dental treatment. Furthermore, I will be responsible for any financial obligations incurred for dental treatment . I understand that any outstanding balance is subject to a two percent (2%) monthly finance charge. In the event that I fail to uphold my financial obligations, I am aware that I will be responsible for all reasonable costs of attorney's fees incurred in the collection of my outstanding balance.*

Signature_____Guardian _____ Date_____

Thank you for choosing Periodontics of Southern Illinois