

## PATIENT MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Patient's Physician \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Do you have or have you ever had (✓ if yes):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> Drug allergies (please list) _____    | <input type="checkbox"/> H.I.V. positive       |
| <input type="checkbox"/> A.I.D.S.                     | _____  | <input type="checkbox"/> Kidney trouble        |
| <input type="checkbox"/> Arthritis                    | _____  | <input type="checkbox"/> Liver trouble         |
| <input type="checkbox"/> A stroke                     | <input type="checkbox"/> Epilepsy                              | <input type="checkbox"/> Lung disease          |
| <input type="checkbox"/> Any blood disorders          | <input type="checkbox"/> Heart trouble (please describe) _____ | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Asthma                       | _____  | <input type="checkbox"/> Rheumatic fever       |
| <input type="checkbox"/> Bleeding problems            | <input type="checkbox"/> Heart murmur                          | <input type="checkbox"/> Radiation therapy     |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Hepatitis                             | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Congenital heart problem     | <input type="checkbox"/> Hemophilia                            | <input type="checkbox"/> Ulcers                |
|   |  | <input type="checkbox"/> Venereal disease      |

**Are you (✓ if yes):**

- |   |  |
|---|--|
| <input type="checkbox"/> being treated for any illness  | <input type="checkbox"/> taking aspirin daily                        |
| <input type="checkbox"/> a smoker                       | <input type="checkbox"/> taking any medications (please list): _____ |
| <input type="checkbox"/> a user of smokeless tobacco    | _____  |
| <input type="checkbox"/> a user of alcohol              | _____  |
| <input type="checkbox"/> taking or have taken cortisone | _____  |

Do you have any disease or health problems not listed above? Yes \_\_\_\_\_ No \_\_\_\_\_(please describe): \_\_\_\_\_

**Women: Are you (✓ if yes):** \_\_\_\_\_ pregnant \_\_\_\_\_ nursing \_\_\_\_\_ taking birth control pills

## PATIENT DENTAL HISTORY

**Do you have or have you ever had (✓ if yes):**

- |   |  |
|---|--|
| <input type="checkbox"/> A reaction to an anesthetic    | <input type="checkbox"/> Jaw popping or jaw pain                 |
| <input type="checkbox"/> Bad breath                     | <input type="checkbox"/> Loose teeth                             |
| <input type="checkbox"/> Bleeding gums                  | <input type="checkbox"/> Previous periodontal treatment          |
| <input type="checkbox"/> Difficulty in chewing          | <input type="checkbox"/> Teeth sensitive to hot, cold, or sweets |
| <input type="checkbox"/> Grinding or clenching of teeth |  |

Why did you make this appointment? \_\_\_\_\_

Date of last dental appointment? \_\_\_\_\_ Who is your dentist? \_\_\_\_\_

How many times have you had your teeth cleaned in the last 3 years? \_\_\_\_\_ When was the last time? \_\_\_\_\_

Are you satisfied with the appearance of your teeth? yes \_\_\_\_\_ no \_\_\_\_\_

Are you apprehensive about dental treatment? yes \_\_\_\_\_ no \_\_\_\_\_

I hereby grant permission to Dr. Kohlhorst and his staff for the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The medical and dental information answered on this form is correct to the best of my knowledge. I will notify this office if there are any changes in my Medical or Dental History.

\_\_\_\_\_  
Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Periodontist/Staff

\_\_\_\_\_  
Date