Professional Periodontics and Dental Implants

Ivan P. Streif, D.D.S.

Medical History

Name:____ Birthdate:________________________

Are you currently under a physician's care? .... Yes No
For what reason? ____
Are you taking any medications (prescription and nonprescription)? .... Yes No
What?____
Are you allergic to anything you know of (including medications, latex or metals)? ...... Yes No
What? ____
Do any medications upset your stomach? .... Yes No
What? ____
Have you ever been hospitalized? .... Yes No
For what reason? ____

Do you smoke or chew tobacco? .... Yes No
How much? ____

HAVE YOU EVER HAD:

Breathing problems such as asthma or lung disease..................................	Yes	No
Prolonged bleeding from a cut or tooth extraction..................................	Yes	No
Hepatitis or Jaundice..	Yes	No
Diabetes..	Yes	No
Immune system disorders...	Yes	No
Epilepsy or seizures..	Yes	No
High or low blood pressure…(please circle high or low)	Yes	No
Heart murmur or congenital heart problems..	Yes	No
Rheumatic fever..	Yes	No
Heart attack or heart disease..	Yes	No
Prosthetic joints or implants...	Yes	No
Fainting spells...	Yes	No
Nervous disorders...	Yes	No
Chemical dependency or alcoholism..	Yes	No
Arthritis..	Yes	No
Liver or kidney disease...	Yes	No
Cancer, tumor or malignant growth..	Yes	No
Radiation or chemotherapy..	Yes	No
Osteoporosis...	Yes	No
Organ transplant...	Yes	No

Females: Are you pregnant.. Yes No
Are you taking contraceptives (birth control medication).................................... Yes No
Are you taking hormone supplements.. Yes No

Do you have any other health concerns we should be aware of?

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Patient Signature: ______________________________________ Date: ________________________