

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 or 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

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 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

- 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?

Patient Signature: Date: