ANDREW C. DREYER, DDS, MS
PERIODONTICS & DENTAL IMPLANTS

MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Physicians (please list your family physician and any medical specialists you see at least once a year):

Name	Address	City	Phone #	Specialty

Approximate date of last physical examination:_____

Medications that you take on a regular basis:

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

Yes	No	Allergic reaction to (select all that apply)			
		Latex	Penicillin	Aspirin	Codeine
		Narcotics	Acetaminophen	Local Anesthetics	Other
Yes	No	Heart attack or heart disease (date ___)			
Yes	No	Heart surgery (date_____)			
Yes	No	Stroke (date_____)			
Yes	No	Mini stroke/TIA (date_____)			
Yes	No	High blood pressure			
Yes	No	Congestive heart failure			
Yes	No	Angina (chest pains)			
Yes	No	Irregular heart beat			
Yes	No	Artificial heart valve			
Yes	No	Rheumatic fever, rheumatic heart disease			
Yes	No	Bacterial endocarditis (SBE)			
Yes	No	Congenital heart disease			
Yes	No	Immunosuppressive condition (select all that apply)			
		Steroid therapy (e.g. Prednisone)	Radiation therapy	Chemotherapy	
		SLE (Lupus)	Rheumatoid arthritis	HIV	
		Organ transplant	Spleen removed	Other	
Yes	No	Artificial implants or devices (select all that apply)			
		Hip	Knee	Ankle	Shoulder	Other
		Date(s) placed:_____				
Yes	No	Other artificial implants or devices			
Yes	No	Bleeding problem, anemia, other blood diseases			
Yes	No	Diabetes			
Yes	No	Thyroid disease			
Yes	No	Nervous system disease or seizures			
Yes	No	Stomach (i.e. ulcer) or intestinal diseases (Crohn's, IBS, etc.)			
Yes	No	Kidney disease			
Yes	No	Hepatitis (A, B, C, or D)			
Yes	No	Other liver disease			
Yes	No	Arthritis (Osteo or Rheumatoid)			
Yes	No	Other muscle or joint disease			
Yes	No	Asthma			
Yes	No	Tuberculosis			

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Yes No Other lung disease
Yes No Mental health condition – specifically:_____
Yes No Physical or mental disabilities that may require special care
Describe:_____
Yes No Do you have or have you ever been treated for cancer?
If you answered yes, how was it treated?_____
Yes No Do you have any diseases, conditions, or problem not listed here?
Describe:_____
Yes No Have you ever been hospitalized or had surgery?
Describe:_____
Yes No Dr you have any undiagnosed symptoms?
Describe:_____
Yes No Are you, or have you ever been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)
Yes No Do you smoke tobacco products?
How much and how often?_____
Yes No Do you regularly consume alcoholic products?
How much and how often?_____
Yes No Do you regularly take herbal medicines or dietary supplements? (select all that apply)

Echinacea	Garlic	Ginger	Kava	Valerian	Feverfew
Ginkgo	Ginseng	St. John's Wort	Vitamin E	Other:	

Yes No Have you received injections or taken medication for past osteoporosis therapy or bone cancer?
(Examples are: Fosamax, Boniva, Prolia, etc.)
Yes No Have you taken steroids (cortisone, etc.) in the past 12 months? Date:_____
Yes No Have you had a prolonged illness and hospitalization experience during the past 5 years?
Describe:_____

Females
Yes No Are you or could you be pregnant
Yes No Do you take birth control pills?
Yes No Have you completed Menopause?
Yes No Do you have hormone replacement (HRT)?
Yes No Are you nursing?

Other Health information of concern?_____
_____

At each dental appointment please advise us of changes in your health status.
(e.g. pregnancy, cardiac distress, hospitalization, prolonged illness,…)

Patient signature:_____ **Date:**_____

Thank you for helping us to help you

Reviewed by:	**Premed. indicated?**	**Date:**