Periodontics & Implants
Mark Kolozenski, DDS, MS

PATIENT NAME_____

Office use only
BP=
_____ / _____

Have you ever had any of the following diseases or problems?:

☐ Yes ☐ No Cardiovascular disease
☐ Yes ☐ No Congenital heart disease / defect
☐ Yes ☐ No Mitral valve prolapse (MVP)
☐ Yes ☐ No Artificial / damaged heart valves
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Low blood pressure
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Angina / chest pain
☐ Yes ☐ No Heart attack / stent placement
☐ Yes ☐ No Stroke
☐ Yes ☐ No Blood thinner (Coumadin, Warfarin, Xarelto, Plavix)
☐ Yes ☐ No Congestive heart failure
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Rheumatic fever / disease
☐ Yes ☐ No Anemia / abnormal bleeding
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Blood transfusion
☐ Yes ☐ No AIDS or HIV infection
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Autoimmune disease
☐ Yes ☐ No Rheumatoid arthritis
☐ Yes ☐ No Systemic lupus erythematous
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Sinus trouble
☐ Yes ☐ No Asthma
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Sleep disorder / Sleep Apnea / CPAP
☐ Yes ☐ No Do you snore?
☐ Yes ☐ No Epilepsy, fainting spells or seizures
☐ Yes ☐ No Neurological disorders
☐ Yes ☐ No Mental health disorders
☐ Yes ☐ No Eating Disorder

☐ Yes ☐ No Malnutrition
☐ Yes ☐ No GERD / acid reflux / heartburn
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Gastrointestinal disease, Crohn's, Colitis
☐ Yes ☐ No Hepatitis, jaundice, or liver disease
☐ Yes ☐ No Diabetes (type I or II), Last A1C: _____ Date: _____
☐ Yes ☐ No Kidney problems
☐ Yes ☐ No Cancer / chemotherapy / radiation
☐ Yes ☐ No Persistent swollen glands in neck
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Chronic Pain
☐ Yes ☐ No Severe headaches / migraines
☐ Yes ☐ No Recurrent infections
☐ Yes ☐ No Severe or rapid weight loss
☐ Yes ☐ No Sexually transmitted disease
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bisphosphonate (Fosamax, Actonel, Boniva, Prolia, Reclast, etc) for osteoporosis / Paget's disease
☐ Yes ☐ No Do you use controlled substances (medicinal marijuana, recreational marijuana, other drugs)?
☐ Yes ☐ No Do you use tobacco (smoking, e-cig, vape, chew, etc)?
☐ Yes ☐ No Do you drink alcoholic beverages?
☐ Yes ☐ No Has it been recommended that you premedicate with antibiotic prior to dental treatment because of a *medical* condition?
☐ Yes ☐ No Do you have any disease/condition/problem not indicated above that you think we should know about? _____
_____

WOMEN ONLY

☐ Yes ☐ No Pregnant? Number of weeks_____
☐ Yes ☐ No Nursing?
☐ Yes ☐ No Taking birth control pills?
☐ Yes ☐ No Breast augmentation / implants (may require antibiotic premed)

☐ Yes ☐ No Are you currently under the care of a physician Name:_____Phone:_____
☐ Yes ☐ No Have you had a serious illness/operation/hospitalization in the past 5 years? _____
☐ Yes ☐ No Are you currently taking any prescription or OTC medicine(s)? If so, please list all:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Are you ALLERGIC to or have you ever had a reaction to:

☐ Yes ☐ No Local Anesthetics
☐ Yes ☐ No Aspirin / NSAIDS
☐ Yes ☐ No Food
☐ Yes ☐ No Metals
☐ Yes ☐ No Latex
☐ Yes ☐ No Sulfa drugs
☐ Yes ☐ No Iodine
☐ Yes ☐ No Animals
☐ Yes ☐ No Penicillin / other antibiotics
☐ Yes ☐ No Codeine or other narcotics
☐ Yes ☐ No Barbiturates or other sedatives
☐ Yes ☐ No Other _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND THAT THE INFORMATION GIVEN ON THIS FORM IS ACCURATE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND THAT MY DENTIST AND HIS STAFF WILL RELY ON THIS INFORMATION FOR TREATING ME. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS STAFF, RESPONSIBLE FOR ANY ACTION THEY TAKE OR DO NOT TAKE BECAUSE OF ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE_____DATE_____