DR Sarah Johnston INC • PERIODONTICS

Medical History **Private & Confidential**

Medical Alert: _____

Patient name:_____
Address:_____
_____
Phone: _____(H)_____(W)_____(C)
Email:_____
Occupation:_____
Insurance provider:_____
Care card #: _____
Date of Birth _____
Physician _____
Dentist _____
Emergency Contact:_____(Name)_____(Ph #)

YES	**NO**	
□	□	Are you under a physician's care at present? If yes, why?: _____ _____
□	□	Have you ever been a patient in a hospital, undergone any surgery or suffered from any major illness. If yes indicate reason: _____ _____
□	□	Are you taking any medications or nonprescription drugs of any kind? Please list name of drug, what condition the drug is for and dosage. (please include over the counter meds e.g. baby aspirin): _____ _____ _____ _____
□	□	Have you ever taken any cortisone or steroid medication. If yes, when?:_____
□	□	Have you ever taken or are you presently taking medications for osteoporosis / osteopenia?
□	□	Do you have any allergies? If yes, please note the substance/drug to which you are allergic:_____ _____
□	□	Are you allergic to latex or latex products?
□	□	Have you ever had a peculiar reaction to anesthetics, medicines or injections? If yes, describe what happened. _____

Do you have or have you ever had any of the following diseases or conditions:

YES	NO	
□	□	Heart trouble, heart attack or stroke
□	□	Rheumatic fever or heart murmur
□	□	Difficulty breathing
□	□	Chest pain
□	□	High blood pressure
□	□	Diabetes. If yes what was your recent HbA1c value:_____
□	□	Epilepsy, convulsions, or seizures
□	□	Kidney disease
□	□	Infectious or communicable diseases, if yes specify: _____
□	□	Yellow jaundice or liver disease
□	□	Indigestion, heartburn or ulcer
□	□	Nervous disorders (depression, anxiety etc…)
□	□	Bone, muscle or joint disorders (e.g. arthritis, osteoporosis etc.)
□	□	Cancer
□	□	Artificial joints or valves
□	□	History of Hepatitis A,B,C (Circle if applicable which type)
□	□	HIV positive
□	□	Immune deficiency
□	□	Are there any disease or medical problems that run in your family (i.e. brothers/sisters, mother/father)? Specify: _____
□	□	Do you bleed excessively?
□	□	Are you prone to infections?
□	□	Do you faint easily?
□	□	Do you or have you ever used tobacco products? Packs/day:_____
□	□	Do you consume alcohol? How much per day?___wine/beer/spirits
□	□	Have you used any recreational drugs in the past 24 hours? What?

FEMALE:

□	□	Are you pregnant? If yes what is your due date?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: