Periodontal Patient Medical History Form

Patient Information

First Name

Date of Birth

Last Name

Phone Number

Address

Emergency Contact

Name

Phone

Relationship

Physician Information

Physician's Name

Physician's Phone

Medical Conditions

- [ ] Heart Disease
- [ ] Diabetes

High Blood Pressure

Stroke

Epilepsy

Bleeding Tendency

Osteoporosis

Asthma

Other Conditions

Allergies

List any allergies

Medications

List any medications you are currently taking

Lifestyle

Do you smoke?

Yes

No

Do you consume alcohol?

Yes

No

Dental History

Have you had previous periodontal treatment?

Yes

No

Dental Concerns

Women Only

Are you pregnant?

Yes

No

Are you nursing?

Yes

No