Salem Periodontal Specialists, PC
Periodontics And Dental Implants

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Medical-Dental History

Email: _____ Date: _____

Name:_____ Medical Doctor:_____

Your Emergency contact: _____Phone: _____

Have you been under the care of a Physician in the last 2 years? Yes____ No__
If Yes, please explain:_____

Current Medications you are taking:_____

_____

_____

Have you been told to take antibiotics prior to dental treatment? Yes____ No __
Have you been hospitalized or had any surgeries in the last 5 years? Yes____ No__
If Yes, please explain _____

_____

Are you sensitive or allergic to Novocain, codeine, aspirin or any other medication? Yes____ No__
If yes, please list_____

Are you allergic to or had a bad reaction to Latex or Metals? Yes____ No__
If Yes, please explain:_____

Have you taken Fosamax (Alendronate) or other osteoporosis drugs? Yes____ No__ If Yes how long _____
Do you smoke or use smokeless tobacco? Yes____ No__ If yes how long? _____ Packs per day_____
Do you use alcohol? Yes____ No__ How often?_____

Please indicate if you have had or have any of the below conditions; if so, when?

❑Heart Attack	❑Rheumatic Fever	❑Arthritis	❑Neurological Disorders	❑Alcohol or Drug Addiction
❑Heart Surgery	❑Stroke	❑Asthma	❑Epilepsy or Seizure	**Women: Are you / or could you be**
❑Heart Disease	❑Ulcers or Stomach Trouble	❑Tuberculosis	❑Fainting or Dizzy spells	**pregnant?_____ Due Date_____**
❑Chest Pains	❑Diabetes	❑Hepatitis A, B, C	❑Shortness of Breath	Do you have a Family History of:
❑Congenital Heart Disease	❑Radiation or Chemo Therapy	❑Blood Thinners	❑Kidney Disease	❑Diabetes ❑Cancer ❑Gum Disease
❑Heart Murmur	❑Anemia	❑H.I.V. Positive	❑Glaucoma	**Please list other illnesses/conditions**
❑High/Low Blood Pressure	❑Hearing Problems	❑Psychiatric Care	❑Cancer or Tumors	**on the reverse of this page.**
❑Artificial Pins/Joints/Valves	❑Sinus Trouble	❑Mitral Valve Prolapse	❑Blood Transfusion	