Levenson Periodontal Associates, Inc.
Patient History Form

Patient Name:_____ Sex: M or F Birth Date: _____ Age:_____

MEDICAL HISTORY

Many medical conditions may affect the treatment we can do for you. Do you have or have you ever had any of the following?

0 Mitral Valve Prolapse	0 Anemia	0 Epilepsy or Seizures	0 Thyroid Disease
0 Heart Condition or Disease	0 Stroke	0 Arthritis or Rheumatism	0 Kidney Disease
0 Heart Murmur	0 Scarlet Fever	0 Hepatitis A (infectious)	0 Liver Disease
0 Rheumatic Fever	0 Asthma	0 Hepatitis B (serum)	0 Glaucoma
0 High Blood Pressure	0 Emphysema	0 Hay Fever	0 Drug Addiction
0 Low Blood Pressure	0 Cough	0 Sinus Trouble	0 Venereal Disease
0 Congenital Heart Lesions	0 Diabetes	0 Psychiatric Treatment	0 Bruise Easily
0 Blood Transfusion	0 AIDS	0 Tuberculosis (TB)	0 Nervousness
0 Artificial Heart Valve	0 Ulcers	0 Allergies or Hives	0 Sickle Cell Disease
0 Heart Surgery	0 Hemophilia	0 Chemotherapy	0 Artificial Joint Hip/Knee Replacement
0 Angina Pectoris			

Please check the following that apply:	**Yes**	**No**		**Yes**	**No**
Have you been a patient in the hospital during the past two years?	0	0	Do your ankles swell during the day?	0	0
Have you been under the care of a medical doctor in the past two years?	0	0	Do you use more than 2 pillows to sleep?	0	0
Have you taken any medicine or drugs in the past two years?	0	0	Are you on a special diet?	0	0
Have you seen your Physician in the past two years?	0	0	Do you feel you are presently healthy?	0	0
Have you ever had any excessive bleeding requiring treatment?	0	0	Do you take aspirin daily?	0	0
Do you ever wake up from sleep short of breath?	0	0	Do you smoke or chew tobacco?	0	0
Have you ever had cosmetic surgery?	0	0	If so, circle which and list how often _____		
Do you participate in recreational drug use?	0	0	Do you consume alcoholic beverages?	0	0
If so, list what kind & how often _____.			If so, how often? _____		
Have you lost or gained more than 10 lbs in this past year?	0	0	Do you take vitamins or supplements?	0	0
Have you been advised to take antibiotics for dental treatment by your Doctor due to prosthetic joint implants or for any other reason ?	0	0	Have you ever been told you have cancer?	0	0
Women: Are you pregnant? _____ Are you on birth control?	0	0	Are you taking or have you taken medicine	0	0
Do you have plans to become pregnant?	0	0	for Osteoporosis or bone cancer? Name_____		
Do you have any allergies to medicines?	0	0	Please List: _____		
Do you have any allergies to foods?	0	0	Please List: _____		
Do you have any disease or problem not listed above?	0	0	Please Explain: _____		

What medications are you presently taking? (Please include natural supplements & vitamins): _____

Date & BP:_____ Date & BP:_____ Date & BP:_____

Date: _____ Update: _____ DDS Initials:_____

DENTAL HISTORY

Please check the following that apply:	**Yes**	**No**		**Yes**	**No**
Are you having any discomfort?	0	0	Do your gums ever bleed?	0	0
Do you feel you have unpleasant breath or taste in your mouth?	0	0	Do you have sensitive teeth?	0	0
Have you ever had a bad experience at a dental office?	0	0	Are you nervous about dental treatment?	0	0
Are you aware of grinding or clenching of your teeth?	0	0	Does food lodge between your teeth?	0	0

How do you take care of your teeth? Brush_____ How Often? _____ Floss_____ How Often?_____

Is there anything about your mouth that concerns you now?_____

What could we do to make you more comfortable? _____

How do you feel about your teeth? _____

How do you feel about dentures? _____

What goals do you want to accomplish with treatment? _____

What brings you to this office today? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date _____ Patient (or legal guardian) Signature: _____