PATIENT HEALTH HISTORY *For the office of Drs. Steven Seibert & Yoolim Kim* Date _____

Patient Name _____ Date of Birth _____ _____ _____

Address _____ City _____ State _____ Zip _____

Home #: _____ Cell #: _____ **List allergies to any Medications** _____ _____

Height _____ ft. _____in. Weight _____ lbs. _____ _____

Occupation _____ _____ _____

Do you take a Pre-Medication before dental appointments? Yes / No If yes - please list pre-medication _____

Name of spouse (if applicable) _____ Phone # _____-_____-_____

Name of family member or friend to contact in case of an emergency (if other than spouse)_____

Relationship to patient _____ Phone # _____-_____-_____ Address _____

Name of person completing form *(if other than patient)* _____ Relationship to patient _____

All information provided on this form is for our records only and will be kept confidential. This information is vital to allow us to provide appropriate care for you.

Medical Information

Circle Y for YES, N for NO, or DK if you DON'T KNOW the answer to the questions.

Are you now under the care of a physician?.....**Y / N / DK**

Physician Name: _____ Phone: ( ) _____

Address/City/State/Zip: _____

Are you in good health?.....**Y / N / DK**

Has there been any change in your general health within the past year?..... **Y / N / DK**

If yes, what condition(s) is/are being treated?

_____

_____

Date of last physical exam? _____

Have you ever had any serious illness, operation, or been hospitalized?.....**Y / N / DK**

If yes, what was the illness or problem?

_____

_____

Have you had a serious illness, operation, or been hospitalized in the **past 5 years**?.....**Y / N / DK**

If yes, what was the illness or problem?

_____

_____

_____

Do you wear contact lenses? ..... **Y / N / DK**

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?..... **Y / N / DK**

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis, Paget's disease, or cancer? ..... **Y / N / DK**

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... **Y / N / DK**

Date Treatment began: _____

Do you use Marijuana or Recreational Drugs? .....**Y / N / DK**

Do you use tobacco (smoking, snuff, chew, bidis)? .....**Y / N / DK**

If so, how interested are you in stopping?

(Circle One) **VERY / SOMEWHAT / NOT INTERESTED**

Do you drink alcoholic beverages? .....**Y / N / DK**

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? .....**Y / N / DK**

If Pregnant, number of weeks: _____

Nursing? .....**Y / N / DK**

Taking birth control pills or hormonal replacement? .....**Y / N / DK**

Joint Replacement – Have you had an orthopedic total joint (hip, shoulder, knee, elbow, finger) replacement? ..... **Y / N / DK**

Date: _____ If yes, have you had any complications? _____

Does your physician recommend pre-medication (antibiotics) prior to your dental appointments?... **Y / N / DK** Medication Name: _____

Allergies – Are you allergic to or have you had a reaction to:
To all **YES** responses, specify type of reaction.

Local anesthetics_____ **Y / N / DK**

Aspirin _____ **Y / N / DK**

Penicillin or other antibiotics _____ **Y / N / DK**

Barbiturates, sedatives, or sleeping pills _____ **Y / N / DK**

Sulfa drugs _____ **Y / N / DK**

Codeine or other narcotics _____ **Y / N / DK**

Metals _____ **Y / N / DK**

Latex (rubber) _____ **Y / N / DK**

Iodine _____ **Y / N / DK**

Hay fever / seasonal _____ **Y / N / DK**

Animals _____ **Y / N / DK**

Food _____ **Y / N / DK**

Other _____ **Y / N / DK**

PATIENT HEALTH HISTORY (Cont.)

Circle Y for YES, N for NO, or DK if you DON'T KNOW the answer to the questions.

Heart Murmur	Y / N / DK	
Mitral valve prolapse	Y / N / DK	
Artificial heart valves	Y / N / DK	
Rheumatic fever	Y / N / DK	
Cardiovascular disease	Y / N / DK	
Angina	Y / N / DK	
Arteriosclerosis	Y / N / DK	
Congestive heart failure	Y / N / DK	
Ankle Swelling	Y / N / DK	
Coronary artery disease	Y / N / DK	
Damaged heart valves	Y / N / DK	
Heart attack	Y / N / DK	
Low blood pressure	Y / N / DK	
High blood pressure	Y / N / DK	
Congenital heart defects	Y / N / DK	
Pacemaker	Y / N / DK	
Rheumatic heart disease	Y / N / DK	
Stroke	Y / N / DK	
Short of breath	Y / N / DK	
Chest pain upon exertion	Y / N / DK	
Persistent cough / Cough up blood	Y / N / DK	
Skin rash or Hives	Y / N / DK	
Diabetes Specify: Type I or II	Y / N / DK	
Excessive urination	Y / N / DK	
Thirsty much of time	Y / N / DK	
Dry Mouth	Y / N / DK	
Abnormal bleeding	Y / N / DK	
Anemia	Y / N / DK	
Blood transfusion	Y / N / DK	
If yes, date: _____		
Hemophilia	Y / N / DK	
AIDS or HIV infection	Y / N / DK	
Ever tested positive for HIV virus	Y / N / DK	
Osteoporosis	Y / N / DK	
Arthritis	Y / N / DK	
Rheumatoid arthritis	Y / N / DK	
Autoimmune disease	Y / N / DK	
Painful swollen joints	Y / N / DK	
Systemic Lupus Erythematosus	Y / N / DK	
Asthma	Y / N / DK	
Bronchitis	Y / N / DK	
Emphysema	Y / N / DK	
Sinus trouble	Y / N / DK	
Tuberculosis	Y / N / DK	
Eating disorder	Y / N / DK	
Malnutrition	Y / N / DK	
Stomach Ulcers	Y / N / DK	
Gastrointestinal disease	Y / N / DK	
G.E. Reflux / persistent heart burn	Y / N / DK	
Hepatitis, jaundice or liver disease	Y / N / DK	
Sleep disorder	Y / N / DK	
Mental health disorders Specify: _____	Y / N / DK	
Recurrent infections Type of infection: _____	Y / N / DK	
Kidney problems	Y / N / DK	
Night sweats	Y / N / DK	
Persistent swollen glands in neck	Y / N / DK	
Glaucoma	Y / N / DK	
Severe headaches / migraines	Y / N / DK	
Sexually transmitted disease Specify: _____	Y / N / DK	
Epilepsy	Y / N / DK	
Fainting spells or seizures	Y / N / DK	
Neurological disorders Specify: _____	Y / N / DK	
Chronic pain	Y / N / DK	
Thyroid problems	Y / N / DK	
Severe or rapid weight loss	Y / N / DK	
Cancer / Chemotherapy / Radiation Treatment	Y / N / DK	
Regularly exposed to x-rays or other ionizing radiation	Y / N / DK	

Other: _____

_____

Are you taking any of the following:

Antibiotics or sulfa drugs	Y / N / DK
Anticoagulants (blood thinners)	Y / N / DK
Medicine for high blood pressure	Y / N / DK
Cortisone (steroids)	Y / N / DK
Tranquilizers	Y / N / DK
Antihistamines	Y / N / DK
Aspirin	Y / N / DK
Ibuprofen / Tylenol	Y / N / DK
Insulin, Metformin, Glucophage, Orinase or similar drug	Y / N / DK
Digitalis	Y / N / DK
Nitroglycerin	Y / N / DK
Viagra or similar drugs	Y / N / DK
Oral Contraceptive or other hormonal therapy	Y / N / DK
Other	Y / N / DK

Are you taking or have you recently taken any prescription or over-the-counter medicine(s)? **Y / N / DK**

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

_____

Do you have any disease, condition, or problem not listed above that you think we should know about? **Y / N / DK**

If yes, explain _____

_____

_____

_____

Chief Dental Complaint _____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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 periodontist and his/her 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 periodontist, or any other member of his/her 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 of Patient: _____ Date: _____

Signature of Doctor: _____ Date: _____