The cause of periodontal disease is a combination of many factors and is very complex. Although many of these questions may seem to have nothing to do with your oral condition, they may be contributing influences. All material will be held in strictest confidence.

Family Doctor Name: ______________________ **Family Doctor #:** ______________________

Family Doctor Address: ____

Pharmacy Name: ______________________ **Location:** ______________________

Pharmacy Telephone # ______________________

Do you consider yourself to be in good health? YES NO
Have you been under a physicians care recently? YES NO

If yes, when/why____

Are you taking any medications (including aspirin, vitamins, herbals) YES NO

If yes, which ones____

____

Do you smoke? NO YES – **if yes, how much** ______________________
Have you ever had abnormal bleeding associated with previous surgeries or trauma? YES NO

If yes, when/why____

Do you need to PRE-MEDICATE with ANTIBIOTICS prior to dental treatment? YES NO

If yes, why and what medication/dosage do you take______________________

PLEASE CHECK ANY CONDITION, ILLNESS OR TREATMENT YOU HAVE HAD OR HAVE NOW:

- ○ **heart disease**
- ○ **pacemaker**
- ○ **heart murmur**
- ○ **mitral valve prolapse**
- ○ **heart valve prosthesis**
- ○ **congenital heart lesions**
- ○ **angina**
- ○ **high blood pressure**
- ○ **low blood pressure**
- ○ **HIV positive**
- ○ **venereal disease**
- ○ **anemia**
- ○ **hemophilia**
- ○ **blood transfusion**
- ○ **rheumatic fever**
- ○ **rheumatism**
- ○ **stroke**
- ○ **diabetes**
- ○ **thyroid disease**
- ○ **hepatitis**
- ○ **liver disease**
- ○ **gall bladder disease**
- ○ **kidney disease**
- ○ **ulcers**
- ○ **tuberculosis**
- ○ **emphysema**
- ○ **persistent cough**
- ○ **asthma**
- ○ **osteopenia**
- ○ **osteoporosis**
- ○ **sinus problems**
- ○ **allergies**
- ○ **epilepsy**
- ○ **fainting spells**
- ○ **cancer treatment**
- ○ **melanoma**
- ○ **joint replacement**
- ○ **arthritis**
- ○ **glaucoma**
- ○ **substance abuse**
- ○ **psychiatric care**
- ○ **high cholesterol**

PLEASE CHECK ANY DRUGS YOU ARE ALLERGIC TO OR HAVE HAD A REACTION TO:

- ○ **local anesthesia**
- ○ **aspirin**
- ○ **penicillin**
- ○ **sulfa**
- ○ **iodine**
- ○ **insulin**
- ○ **latex**
- ○ **sedatives**
- ○ **codeine**

OTHER ____
Is there any condition not mentioned above that I should know about? YES NO

If yes, please explain____

WOMEN
Are you pregnant now? NO YES-**if yes, what is your due date**______________________
Are you taking birth control pills? YES NO

I authorize Barry P.Levin,DMD, PC to obtain/release information that may be needed in connection with my condition.

PATIENT NAME: ____

PATIENT SIGNATURE: ______________________ **DATE:** ____________

REVIEWED BY: ______________________ **DATE:** ____________

HEALTH HISTORY