MK PERIODONTICS AND IMPLANTS
MEDICAL HISTORY AND QUESTIONNAIRE

Patient Name: _____ Date: _____

Do you have, or have you had, any of the following?
Please circle all that apply

Height:_____ Weight:_____

I. Skin
Itching _____
Rash _____
Ulcers _____
Pigmentations_____
Lack or loss of body hair_____

II. Extremities
Varicose veins_____
Swollen, painful joints_____
Muscle weakness, pain_____
Bone deformity, fracture_____
Osteoporosis/Osteopenia (circle one)
Joint Replacements_____
Prosthetic joints_____
Type:_____
Premed required/type:_____

III. Eyes
Blurring vision_____
Double vision_____
Drooping of eyelid_____
Glaucoma_____

IV. Ear, Nose, Throat
Dry Mouth_____
Earache_____
Frequent nosebleeds_____
Sinusitis_____
Frequent sore throat_____
Hoarseness_____

V. Respiratory
Sleep Apnea_____
Do you use a CPAP machine?_____
COPD_____
Cough, blood in sputum_____
Emphysema, bronchitis_____
Wheezing, asthma_____
Tuberculosis _____

VI. Cardiac
Shortness of breath_____
Pain, pressure in chest_____
Swelling of ankles_____
Arrhythmia_____
High/low blood pressure_____
Cholesterol_____
Rheumatic or scarlet fever_____
Heart Murmur, attack_____
Prosthetic valves/pacemakers_____

VII.Gastointestinal
Difficulty swallowing_____
Abdominal pain, ulcers_____
Hepatitis, jaundice_____
Liver disease_____
GERD_____

VIII. Genitourinary
Difficulty, pain on urination_____
Blood in urine_____
Excessive urination_____
Kidney infections_____
Sexually transmitted diseases_____

IX. Endocrine
Thyroid Trouble_____
Weight change_____
Diabetes/Type_____
Result/Date most recent HbA1c:_____
Excessive thirst_____

X. Hematopoietic
Easy bruising, excessive bleeding_____
Persistent lymphadenopathy_____
G6PD deficiency_____
Anemia_____
HIV infection, AIDS_____
Leukemia, **problems with immune system**_____
Spleen problems_____

XI. Neurologic
History of Head or Facial Trauma_____
History of Stroke or TIA_____
Frequent headaches_____
Dizziness, fainting_____
Epilepsy_____
Neuritis, neuralgia_____
Tingling/Burning, numbness_____
Paralysis_____

XII. Psychiatric
Nervousness_____
Irritability_____
Depression, Anxiety_____
Nervous breakdown_____

XIII. Growth or Tumor
Radiotherapy/chemotherapy_____

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Do you smoke tobacco and/or consume other recreational drugs? No **Yes/No**
Do you use smokeless tobacco? **Yes/No**
History of alcohol or drug abuse? **Yes/No**

Do you take or have you taken any of these medications?

☐ Etidronate (Didronel)
☐ Tiludronate(Skelid)
☐ Neridronate
☐ Alendronate (Fosamax)
☐ Ibandronate (Bondronat/Boniva)
☐ Risendronate (Actonel)
☐ Clodronate(Bonefos, Loron)
☐ Pamidronate (Aredia)
☐ Olpadronate
☐ Zolendronate (Zometa)

List all medications/supplements you take and for what:

_____
_____
_____
_____

List all medication that cause **allergic reactions and symptoms:**_____

_____

Other disease/medical conditions not listed?_____

_____

_____

FOR WOMEN: Nursing: **Yes/No**
Pregnant/Due Date:_____ **Yes/No**
Contraceptives/other hormones (circle one) **Yes/No**
Have you noted a change in your menstrual pattern? **Yes/No**
Menopausal/premenopausal?

FOR MEN:
Do you have a history of prostate cancer/prostate enlargement? **Yes/No**
Do you take medications for erectile dysfunction? **Yes/No**

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction. I was asked all of the questions on this form and I have answered these questions truthfully and completely. I will not hold my dentist, or any other member his/her staff, responsible for any errors or omissions that I may have made.

_____ _____
Date **Signature of Patient**

_____ _____
Date **Signature of guardian (where applicable)**