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

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? **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:**______________________

____

Are you an organ donor/recipient? **Yes/No**

Other disease not listed?______________________________________

Have you ever been diagnosed with or tested positive for COVID 19? **Yes/No**

Have you received the COVID 19 Vaccine? **Yes/No**

____

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

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)**