O'Neal
Periodontics, PC
Laser Periodontics & Dental Implants

Patient Name: ______________________________________ Occupation: ______________________________________
DOB: ______________________________________ General Dentist: ______________________________________
Name and Address of Physician: ______________________________________ Physician Phone Number: ______________________________________
______________________________________ Date of Last Medical Visit: ______________________________________

Have you had periodontal disease in the past? Yes No	Have you been told to take antibiotics before dental treatment? Yes No
Have you been hospitalized in the last 5 years? If so, please explain:	Are you presently being treated for any illness or medical condition? If so, please list:

Do you currently have, or have you ever had:

Heart trouble or heart murmur?	Yes	No	IV drugs for osteoporosis/osteopenia?	Yes	No
Chest pain or angina?	Yes	No	Oral drugs for osteoporosis/osteopenia?	Yes	No
Pacemaker?	Yes	No	Diabetes?	Yes	No
High blood pressure?	Yes	No	Thyroid trouble or goiter?	Yes	No
High cholesterol?	Yes	No	Kidney or bladder trouble?	Yes	No
Artificial heart valve?	Yes	No	Hepatitis, jaundice, or liver disease?	Yes	No
Heart attack (myocardial infarction)?	Yes	No	Ulcers or stomach trouble?	Yes	No
Stroke or transient ischemic attack (TIA)?	Yes	No	Fainting or dizziness?	Yes	No
Knee, hip or other joint replacement?	Yes	No	Epilepsy or seizures?	Yes	No
Arthritis?	Yes	No	Depression or anxiety?	Yes	No
Transplant or implant?	Yes	No	Psychological problems?	Yes	No
Tuberculosis?	Yes	No	Drug addiction?	Yes	No
Shortness of breath/lung problems?	Yes	No	Memory loss?	Yes	No
Sinus problems?	Yes	No	Cancer or radiation treatment?	Yes	No
Hay fever or asthma?	Yes	No	Surgery/radiation of growth/condition in mouth?	Yes	No
Glaucoma?	Yes	No	HIV/AIDS?	Yes	No

What drugs/medications do you take or have you taken in the past year? Please list medication and dosage (or provide a list):
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Do you take any pain medication (aspirin, etc) regularly?	Yes	No	Do you use tobacco? If so, how much?	Yes	No
Do you take any blood thinners?	Yes	No	Do you use recreational drugs?	Yes	No
Have you had abnormal bleeding from dental treatment?	Yes	No	Do you take herbal supplements/vitamins?	Yes	No

Are you allergic to or have you reacted adversely to the following:

Local Anesthetics (Novocaine)?	Yes	No	Codeine or other narcotics?	Yes	No
Aspirin or ibuprofen?	Yes	No	Nitrous oxide (laughing gas)?	Yes	No
Barbiturates, sedatives, or sleeping pills?	Yes	No	Latex?	Yes	No
Penicillin, tetracycline, sulfa-based drugs or other antibiotics? Please list:	Yes	No	Allergies to other medications? Please list:	Yes	No

Do you have any condition, problem or disease not mentioned above? Yes No If yes, please explain:
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____

Women: Are you pregnant? Yes No Are you taking birth control pills? Yes No

Your comments or concerns:
____
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Patient Signature ______________________________________ Date ______________________