NORTHERN PERIODONTICS & IMPLANT DENTISTRY

VAUGHN A. McGRAW, D.D.S., M.S. MICHAEL R. DOCTOR, D.D.S., M.S.

Name_		Home Phone			Wor	rk Phone		
Addres	S	City			State	Zip		
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	S _k							
		Answers to the following questions are for ou	ır records	and w	ill be considered c	onfidential.		
Yes	No							
		Do you consider yourself to be in good general health?	Approxir	nate d	late of your last ph	nysical examinati	on:	
		Are you presently or have you recently been treated by a physician for any condition? Please List:	Are you following	•	c or have you rea	cted adversely to	any of the	
			YES					
					Local Anesthetic			
		Llava vay avar had a sarious illaces or assertion?			Penicillin or any			
u	u	Have you ever had a serious illness or operation?			Aspirin Codeine			
					lodine			
					Sulfa			
		Have you lost or gained more than 10 pounds in the			Latex			
		last year?			Other			
u	u	Do you use tobacco (smoking/chewing)?packs/day						
		Do you take aspirin or aspirin products on a regular basis?						
		Are you now taking any other medicines (drugs, vitamins, pills or herbs)?			Have you taken bisphosphonate medication (Fosamax, Boniva, Actonel, Zometa or Reclast) in the past?			
		Which?	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	M OKU	V			
		1 5	WOME!	N ONL	.Y Are you pregnant or nursing?			
		<u>6</u>				oirth control med	ication?	
		37				rgone or are you		
		4 8			menopause?	•		

		have you had		- 175			2				
YES	NO		YES I	OV					YES	NO	
	0	Rheumatic Fever	0		Radiation T		1		0		Latex or Metal Sensitivity
	0	Heart Murmur	0		Chemothera	ару			0	0	Allergies or Hives
		Mitral Valve Prolapse	0		Tumors				0		Sinus Trouble
		Artificial Heart Valve	0		Arthritis/Rhe	eumati	sm				Venereal Disease
			0		Cortisone M	/ledicat	ion				Cold Sores or Fever Blisters
		Heart (surgery, disease, attack)	0		Diet (specia		ctions	3)	0		Blood Transfusion
		Artificial Joints (hip, knee, etc.)	0		Kidney Trou	uble			0		Hemophilia
		Heart Pacemaker	0		Jicers				0		Bleeding Problems
		Diabetes			Thyroid Cor	ndition			0		Bruise Easily
	0	Hepatitis A B C		□G	Glaucoma				0	0	Liver Disease
		AIDS, ARC, HIV Infection		O E	Emphysema	а			0		Neurological Disorders
	0	High Blood Pressure			Chronic Co	ugh			0	0	Epilepsy or Seizures
		Low Blood Pressure			l'uberculosi						Fainting or Dizzy Spells
		Chest Pain	0		Asthma or I	Hay fev	/er				Psychiatric/Psychological Ca
		Stroke		o s	Sleep Apne	a			0		Frequent Severe Headaches
	0	Osteoporosis/Osteopenia									
Vame	of pr	ently do you visit your dentist?evious dentist:				ar' g	100				ntal Cleaning
lame	of pr					YES	100	Have yo	ı ever h	ad a	ntal Cleaning ny of the following ? date:
Vame YES	of pr	evious dentist: Do your gums bleed or hurt? Have any of your teeth recently se				YES	NO O	Have yo Periodor	u ever h tal treat	ad ai	ny of the following ? date:
Name YES	of pr NO	evious dentist: Do your gums bleed or hurt?	parated, (creation		YES	NO 🗆	Have you Periodor Orthodor Your tee	u ever h tal treat htic treat	ad ar ment tmen	ny of the following ? date: t? date: the bite adjusted? date:
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Patient's/Parent's Signature