MUDGIL

PERIODONTICS AND
IMPLANT DENTISTRY

MEDICAL HISTORY

FIRST NAME: MIDDLE NAME: LAST NAME:

SEX: DATE OF BIRTH:

REASON FOR VISIT:

ARE YOU IN PAIN?: HOW LONG?:

( ) EXAM ( ) EMERGENCY ( ) CONSULTATION

LAST DENTAL EXAM: LAST DENTAL X-RAYS:

PREVIOUS DENTIST:

DO YOU NEED PRE-MEDICATION?

(Y) (N) (UNSURE)

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PLEASE ANSWER THE FOLLOWING QUESTIONS

Are you allergic to any medications? Y N

If yes, please list:

Do you have any other allergies? Y N

If yes, please list:

Do you currently take any medications? Y N

If yes, please list:

Have you had any surgeries? Y N

If yes, please list:

Female patients, are you pregnant or nursing? Y N

If no, are you currently trying to get pregnant? Y N

Do you smoke cigarettes? QUIT Y N

Do you drink alcohol? Y N

If yes, how many drinks on average per day?

Do you use any illicit drugs? Y N

If yes, which ones?

HAVE YOU HAD (OR DO YOU CURRENTLY HAVE) ANY OF THE FOLLOWING?

(Please Place A Check Next To All That Apply)

- ◯ DISCOMFORT OR CLICKING IN JAW
- ◯ LOST OR BROKEN FILLING(S)
- ◯ LOCKING JAW
- ◯ SWOLLEN OR BLEEDING GUMS
- ◯ TEETH GRINDING
- ◯ STAINED TEETH
- ◯ SENSITIVE TEETH OR GUMS
- ◯ RINGING IN EARS
- ◯ BAD BREATH
- ◯ BLISTERS OR SORES IN MOUTH
- ◯ BROKEN OR CHIPPED TOOTH
- ◯ OTHER

If yes, please describe: