Periodontal Associates, P.A.
Architects of Health
Practice Limited to Periodontics and Implants

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Health Update

Name _____ Date _____

Street _____ City _____ State _____ Zip _____

Birthdate _____ Height _____ Weight _____

Home # _____ Cell # _____ Work # _____

Email _____ Use (circle one) Home/Work/Cell/Email for appointment reminders

In an emergency, whom should we contact? _____ Phone _____

Dentist _____ Date of Last Dental Cleaning _____

Primary Physician _____ Phone _____

Do you take aspirin daily? Yes/No Dose _____ Was this physician prescribed? Yes/No Who? _____

Do you see a cardiologist Yes/No Name _____

Do you have an artificial joint? Yes/No Surgeon _____

Do you use tobacco products? Yes/No What? _____ How much?_____ How long? _____

Do you drink alcohol? Yes/No How much? _____ How often? _____

Have you had any health changes/hospitilizations/surgeries in the past year? Yes/No (please describe) Use separate sheet, if preferred or needed.

Do you have any allergies to medication or food? Yes/No (please list) Use separate sheet, if preferred or needed.

List all prescribed medications with dosages (antibiotics, anticoagulants, steroids, blood pressure meds, insulin, statins, tranquilizers, etc.) Use separate sheet, if preferred or needed.

List all over-the-counter medications/herbal supplements with dosages (vitamins, minerals, St. John's Wort, aspirin) Use separate sheet, if preferred or needed.

Do you have or have you had any of the following? (Please circle yes or no to each)

AIDS/HIV	Yes / No	COPD	Yes / No	Osteoporosis/Osteopenia	Yes / No
Allergies	Yes / No	Diabetes	Yes / No	Pacemaker	Yes / No
Angina	Yes / No	Fainting Spells	Yes / No	Prosthetic Heart Valve	Yes / No
Artificial Joint(s)	Yes / No	Glaucoma	Yes / No	Radiation Treatment	Yes / No
Arthritis	Yes / No	Heart Attack	Yes / No	Respiratory Disease	Yes / No
Asthma	Yes / No	Heart Disease	Yes / No	Rheumatoid Arthritis	Yes / No
Auto Immune Disease	Yes / No	Recent Heart Stent	Yes / No	Seizures	Yes / No
Bacterial Endocarditis	Yes / No	Heart Transplant	Yes / No	Sexually transmitted disease	Yes / No
Bleeding Problems	Yes / No	Hepatitis (Type: _____)	Yes / No	Sinus problems	Yes / No
Blood Disease	Yes / No	High/Low Blood Pressure	Yes / No	Stomach/Intestinal ulcers	Yes / No
Cancer	Yes / No	Hives/Skin Rash	Yes / No	Stroke	Yes / No
Circulatory Problems	Yes / No	Kidney Disease	Yes / No	Thyroid Disease	Yes / No
Congenital Heart Defect	Yes / No	Liver Disease	Yes / No	Tuberculosis	Yes / No
Congestive Heart Failure	Yes / No	Nervous Disorder	Yes / No		

Women: **Are you pregnant? Yes / No** ***Due Date:*** _____ ***OB:*** _____ ***Phone*** _____

Signature _____ ***Date*** _____

Office Use Only: BP _____ *Pulse* _____ *Initials* _____ *Date* _____