Advanced Periodontics P.C.
Creating Smiles

Dr. Shakeel Ahmed
11 Ralph Place, Suite #207, Staten Island, NY 10304
718-727-4141

# Medical History

Name: E-mail: Phone:

Are you in good health? Yes No Height: Weight:

Has there been any change in your general health? Yes No

Your last physical examination was on: Are you now under the care of a physician? Yes No

Name of your physician:

Address of your physician:

Have you ever had a serious illness or operation? Yes No

Have you been hospitalized with any of the following within the last 5 years?

Do you have a persistent cough or cough up blood? Yes No Low/High blood pressure(circle one) Yes No

Venereal Disease Yes No AIDS or HIV+ Yes No

Other:

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No

Do you bruise easily? Yes No

Have you ever required a blood transfusion Yes No

If yes, explain the circumstances:

Do you have any blood disorder such as anemia? Yes No

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? Yes No

## Medications

Are you taking any drug or medication? Yes No

If yes, what?

Are you taking any of the following?

Antibiotics or sulfa drugs Yes No Tranquilizers Yes No

Cortisone (steroids) Yes No

Medicine for high blood pressure Yes No

Insulin, Tolbutamide (Orinase) or similar drug Yes No

Digitalis or drugs for heart trouble Yes No

Osteoporosis Drugs (Fosamax, Aredia, Zometa etc.) Yes No

Aspirin Yes No

Anticoagulants (blood thinners such as Coumadin, Plavix etc) Yes No

Nitroglycerin Yes No

Any natural product, herbal supplement or homeopathic remedy? Yes No

Chemotherapy Drugs Yes No

Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine) Yes No

Oral Contraceptives Yes No

If yes, what are you using?

Other:

## Habits

Do you smoke? Yes No

If yes, how much?

Do you drink alcoholic beverages? Yes No

Do you take any recreational drugs? Yes No

## Do you have any of the following?

Cardiac pacemaker Yes No

A removable dental appliance Yes No

Implants/Artificial prosthesis (Knee joints, elbow pins etc) Yes No

## Do you have, or have you had, any of the following diseases or problems?

Rheumatic fever or rheumatic heart disease Yes No

Hepatitis, jaundice, or liver disease Yes No

Heart Murmur or mitral valve prolapse Yes No

Congenital heart lesions Yes No

Convulsions/epilepsy Yes No

Stroke Yes No

Asthma or hay fever Yes No

Hives or skin rash Yes No

Fainting spells or seizures Yes No

Arthritis Yes No

Inflammatory rheumatism (painful, swollen joints) Yes No

Stomach ulcers Yes No

Kidney trouble Yes No

Tuberculosis Yes No

A tumor or growth Yes No

Radiation therapy or chemotherapy Yes No

Thyroid trouble Yes No

Bleeding tendency /abnormal bleeding Yes No

Are you immunosuppressed? Possibly from transplant surgery Yes No

Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
Yes No

Do you have pain in the chest upon exertion? Yes No

Are you ever short of breath after mild exercise? Yes No

Do you get short of breath when you lie down or do you require extra pillows when you sleep? Yes No

Diabetes Yes No

Do you have to urinate (pass water) more than six (6) times a day? Yes No

Are you thirsty much of the time? Yes No

Does your mouth frequently become dry? Yes No

## Allergy

Are you allergic or have you reacted adversely to:

Local anesthetic Yes No

Barbiturates, sedatives, or sleeping pills Yes No

Sulfa Drugs Yes No

Codeine Yes No

Valium or other tranquilizer Yes No

Aspirin Yes No

Iodine Yes No

Latex Yes No

Penicillin or other antibiotics (such as amoxicillin, clindamycin, erythromycin, Keflex etc) Yes No

Other:

Have you had any serious trouble associated with previous dental treatment? Yes No

If yes, explain:

## For Women Only

Are you pregnant or could you be? Yes No

If yes, when are you due?

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

If yes, what?

Comments:

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist or my surgeon before my next visit.

**Patient's Signature:**

Date:

**Guardian's Signature:**

Date:

**Doctor's Signature:**

Date: