Paul S. Lewis, D.D.S., M.S.
Specialist in Periodontics

MEDICAL HISTORY

Patient:_________________

Medical doctor's name :________________________________
Medical doctor's office location :________________________________

yes no Are you under a physician's care now?
yes no Have you ever had a serious illness or major surgery?
If so, please explain:____
yes no Are you taking any medications or drugs, *including aspirin*?

Medication or Drug	Dosage	Frequency	Condition taking for

yes no Are you allergic to any medications or health-related substances?__________________________
yes no Do you have any other allergies?____
yes no Do you have problems with antibiotics, pain medications, anesthetics or other medications?
yes no Are you allergic to or sensitive to metals or latex?
yes no Do you have any heart problems, such as coronary artery blockage or angina?
yes no Have you ever had a heart attack or bypass surgery?
yes no Do you have high blood pressure?
yes no Do you have any blood disorders, such as anemia or leukemia?
yes no Do you bleed excessively after being cut or injured?
yes no Do you have a heart murmur?
yes no Have you ever had rheumatic fever?
yes no Do you have a pacemaker or an artificial heart valve?
yes no Do you have any lung or respiratory problems?
yes no Do you have asthma?
yes no Do you have any stomach or digestion problems?
yes no Are you diabetic?
yes no Do you have any kidney or urinary problems?
yes no Do you have any liver problems?
yes no Do you have any nerve or nervous system problems?
yes no Do you have epilepsy or some other seizure disorder?
yes no Have you had psychiatric treatment?
yes no Do you have arthritis or rheumatism?
yes no Do you have any artificial joints?
yes no Do you have an electrical devices implanted in your body, such as a cochlear implant or a neurostimulator?
yes no Have you had radiation treatment or chemotherapy for a tumor, growth or other condition?
yes no Do you have or have you had hepatitis?
yes no Do you have or have you had tuberculosis (TB)?
yes no Have you ever tested HIV positive?
yes no Do you have AIDS?
yes no Do you smoke cigarettes?
yes no Do you use other forms of tobacco, such as cigars, a pipe or chewing tobacco?
yes no Do you consume alcoholic beverages?
yes no Do you use or have you used controlled substances, such as cocaine or heroin?
yes no Women: Are you pregnant or think you might be?
yes no Women: Do you use birth control pills?
yes no Do you have any disease, problem or condition not listed above?
If so, please explain:____
yes no Is there anything else about your health not covered on this form that Dr. Lewis should know?

I certify that the information on this form is complete and accurate.

Patient's/Guardian's signature: **Date:**