KRIEGER
PERIODONTICS
& IMPLANT DENTISTRY

MEDICAL QUESTIONNAIRE

NAME_____

ADDRESS_____

AGE_____**HEIGHT**_____**WEIGHT**_____

DATE OF LAST DENTAL VISIT:_____

WHO IS YOUR GENERAL DENTIST?_____

HOW MANY YEARS HAVE YOU BEEN SEEING THIS DENTIST?_____

HOW MANY MONTHS AGO WAS YOUR LAST DENTAL CLEANING?_____

HOW MANY TIMES A YEAR DO YOU HAVE YOUR TEETH CLEANED BY A HYGIENIST?_____

WHO IS YOUR GENERAL PHYSICIAN?_____

HAVE YOU BEEN HOSPITALIZED DURING THE LAST TWO YEARS?_____

PLEASE LIST ANY MEDICATIONS OR DRUGS YOU ARE CURRENTLY TAKING_____
_____

PLEASE LIST ANY KNOWN DRUG ALLERGIES_____

*****LATEX ALLERGY***** ☐**YES** ☐**NO**

HAS YOUR PHYSICIAN DIRECTED YOU TO PREMEDICATE WITH ANTIBIOTICS PRIOR TO DENTAL CARE?
☐**YES** ☐**NO**

DO ANY OF THE FOLLOWING PERTAIN TO YOU?

☐**TOBACCO USE**
☐**HEART TROUBLES**
☐**HEART MURMUR**
☐**PROLAPSED MITRAL VALVE**
☐**HEART SURGERY**
☐**RHEUMATIC FEVER**
☐**DIABETES**
☐**CARDIAC PACEMAKER**
☐**CARDIAC DEFIBRILLATOR**
☐**ARTIFICIAL HEART VALVE**
☐**STROKE**
☐**HYPERTENSION**
☐**LOW BLOOD PRESSURE**
☐**GLAUCOMA**

☐**HEPATITIS** ☐**A** ☐**B** ☐**C**
☐**HIV OR AIDS**
☐**JAUNDICE**
☐**ULCERS**
☐**KIDNEY DISEASE**
☐**PSYCHIATRIC CARE**
☐**SINUS TROUBLES**
☐**PERSISTENT COUGH**
☐**TUBERCULOSIS**
☐**ASTHMA**
☐**EPILEPSY**
☐**ARTHRITIS**
☐**JOINT REPLACEMENT**
☐**CANCER**

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU FEEL WE

SHOULD KNOW ABOUT?_____
PHARMACY NAME:_____**PHARMACY PHONE #**_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____**DATE**_____

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