MEDICAL

Mark Forrest. DMD
Periodontist/Implant Surgeon

Last name: (print) _____ Date: _____

First name: _____ Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Date of birth: _____ Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Street: _____ City:_____ Zip code: _____

Social security #: _____ - _____ - _____ Email: _____

Home phone:_____ Cell phone: _____ Business phone: _____

Best phone number to reach you: ☐ Home ☐ Cell ☐ Business

Employed by: _____ Spouse's name: _____ Spouse's work phone: _____

Spouse employed by: _____ Nearest relative: _____ Phone: _____

Referred by: _____

	Yes	No
1. Are you under a physician's care at present?	☐	☐
2. Do you have any type of health problem?	☐	☐
If yes, if yes please specify		
_____		
_____		
3. Are you taking any medications or vitamins now?	☐	☐
If yes, please list all:		
_____		
_____		
_____		
4. Have you had any seriously illness, or been hospitalized in the last 5 years ?	☐	☐
5. Do you have any of the following?		
A heart valve replacement	☐	☐
A history of infective endocarditis (IE)	☐	☐
A serious congenital heart condition	☐	☐
Heart trouble	☐	☐
Diabetes	☐	☐
Positive HIV or AIDS	☐	☐
A joint replacement (hip, knee, finger, etc.)	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐
Venereal disease	☐	☐
Herpes	☐	☐
Stroke	☐	☐
High blood pressure	☐	☐
Anemia	☐	☐
Dry mouth	☐	☐
Sinus trouble	☐	☐
6. Have you ever had an allergic reaction to any of the following?		
Aspirin	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐
Other medicine: _____	☐	☐
Latex	☐	☐

(over)

	Yes	No
7. Have you ever experienced an unusual reaction to a dental injection (novocaine)?	☐	☐
8. Have you ever had an injury to your face or jaws?	☐	☐
9. Have you ever had surgery for a tumor, growth or skin disease?	☐	☐
10. Have you ever had radiation treatment?	☐	☐
11. Are you short of breath on mild exertion?	☐	☐
12. Do you have chest pain on exertion?	☐	☐
13. Do your ankles swell?	☐	☐
14. Have your ever had prolonged bleeding following a cut or extraction of a tooth?	☐	☐
15. Do you smoke cigarettes?	☐	☐

If **yes**: How many packs/day: _____

How many years have you smoked? _____

16. If you do **not** smoke cigarettes now, did you **ever** smoke?	☐	☐

If **yes:** How many packs/day: _____

How many years did you smoke? _____

When did you stop smoking? _____

17. Do you smoke cigars or a pipe, or use snuff or chewing tobacco?	☐	☐
18. How may times per week do you drink alcoholic beverages? _____		
19. Do you take any recreational drugs?	☐	☐
20. Has any blood relative ever had diabetes?	☐	☐
21. Has any blood relative ever had periodontal (gum) disease?	☐	☐
22. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

If yes, please specify _____

23. Is there anything that you would like to discuss with the doctor in *private*?	☐	☐
24. Are you presently in a relationship with a person who threatens you or physically hurts you?	☐	☐

Women only

25. Do you have osteoporosis?	☐	☐
26. Do you take, or have you ever taken, any medication for osteoporosis?	☐	☐
27. Have you reached menopause?	☐	☐
28. Do you take hormone replacement therapy or birth control pills?	☐	☐

Date of last physical exam: _____

Findings: _____

Physicians (Medical doctors)

Name: _____ Phone: _____ City_____ Specialty: _____

Name: _____ Phone: _____ City_____ Specialty: _____

Name: _____ Phone: _____ City_____ Specialty: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold Dr. Forrest, or any member of his staff, responsible for any actions they take, or do not take, because of errors or omissions that I made in the completion of this form.

Signature: _____

(patient or relative representative)

Who completed this form ?: ☐ Patient ☐ _____