Medical History and Patient Registration

KALAMAZOO PERIODONTICS COMAR & LEJA

Last Name: _____ **First Name:** _____ **Birthdate:**_____

Address:_____ **Phone:**_____

Emergency Contact Name, Relationship: _____ **Phone:**_____

If you are completing this form for another person, what is your relationship to that person?_____

Name and Phone # of Medical Doctor:_____ **Last Physical Exam:** _____

Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

List all medication that you are now taking, please include non-prescription medications/drugs as well:

_____ _____

_____ _____

_____ _____

_____ _____

	YES	NO
Are you in good health? _____	☐	☐
Has there been any change in your health within the past year?_____	☐	☐
Have you had any serious illnesses, operations or been hospitalized in the past 5 years?_____	☐	☐
Have you ever taken Fosamax, Boniva or any osteoporosis drugs? _____	☐	☐
Do you smoke?_____	☐	☐

If yes, how much? _____

Do you have an artificial joint that requires an antibiotic premedication?_____	☐	☐
Do you have abnormal bleeding?_____	☐	☐
Have you ever received a blood transfusion?_____	☐	☐
Do you have any blood disorders such as anemia?_____	☐	☐

WOMEN

Are you pregnant?_____	☐	☐
Are you nursing?_____	☐	☐
Are you taking birth control pills?_____	☐	☐

Are you allergic or ever had a reaction to any of the following?

YES	NO		YES	NO	
☐	☐	Anesthetic	☐	☐	Aspirin
☐	☐	Penicillin or other Antibiotics	☐	☐	Codeine or other narcotics
☐	☐	Sulfa drugs	☐	☐	
☐	☐	Barbituates, sedatives or sleeping pills	Other_____		

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

YES	NO		YES	NO	
☐	☐	Osteoporosis	☐	☐	AIDS or HIV infections
☐	☐	Cancer requiring IV chemotherapy	☐	☐	Cardiovascular disease, angina, heart attack, heart trouble, stroke
☐	☐	Asthma or hay fever			
☐	☐	Fainting spells or seizures	☐	☐	Damaged or artificial heart valves, heart

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (or Patient's guardian) Date

_____

Signature of Dr. Chris Leja Date

☐ ☐ Hepatitis, jaundice, or liver disease murmur,

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□ □ Rheumatic heart disease
□ □ Thyroid problems
□ □ Respiratory problems, bronchitis
□ □ Stomach ulcer or hyperacidity
□ □ Problems with spleen
□ □ Kidney trouble
□ □ High or low blood pressure
□ □ Sexually transmitted infection
□ □ Epilepsy/other neurological diseases
□ □ Diabetes: Last AIC_____ When was it taken?
_____