

Paul Ferguson, DMD / Dorothy Hoyt-Rehm, DMD

Patient Profile

General Information

Name _____ Date of Birth _____
Address _____ Home Phone _____
_____ Work Phone _____
Email _____ Mobile Phone _____

Medical History

Your Physician's Name _____ Physician Phone _____

Have you been seen by your physician during the last 2 years? Yes No

Have you been hospitalized during the last 2 years? Yes No

Are you allergic to Penicillin? Yes No Are you allergic to Latex or Acrylic? Yes No

Please list any other drugs to which you are allergic: _____

Please check any of the following conditions that you have, or have had in the past:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Asthma | <input type="checkbox"/> Artificial Joints/Pins/Implants | |

Please list all medications that you take (include prescription and non-prescription drugs, herbal remedies, etc.):

Have you ever had a problem with prolonged bleeding? Yes No

Have you ever undergone Radiation or Chemotherapy? Yes No If yes, please describe the specific area treated: _____

Have you ever taken any bisphosphonate medication (e.g. for osteoporosis or with chemotherapy)?

Do you have any of the following symptoms: productive cough, coughing up blood, unexplained weight loss, loss of appetite, lethargy/weakness, night sweats, or fever? Yes No If yes, please describe: _____

Females: Are you pregnant or nursing? Yes No

Do you get recurrent attacks of herpes labialis (fever sores) on your lips? Yes No

Please describe any other medical condition(s) that you feel your dentist should know about: _____

Signature: _____ Date: _____

