Daniel A. Karlin, DDS, LLC
Periodontics, Implants
Diplomate of the American Board of Periodontology

MEDICAL HISTORY

Patient Name: _____ **Date:**_____
Date of last complete physical exam:_____Height:_____ Weight:_____
Presently, are you under a physician's care: YES NO (circle one)

DO YOU HAVE, HAVE YOU HAD, ARE YOU:	**Yes**	**No**
Hepatitis or liver disease...	____	____
Epilepsy, convulsions, or seizures...	____	____
Rheumatic fever.....	____	____
Kidney or bladder disease.....	____	____
Diabetes.....	____	____
neurological disease	____	____
Tuberculosis or emphysema.....	____	____
Heart attack.....	____	____
Heart trouble.....	____	____
Heart murmur.....	____	____
Stroke.....	____	____
High/low blood pressure……	____	____
Shortness of breath/swollen ankles	____	____
Chest pains (angina).....	____	____
Osteoporosis/osteopenia.....	____	____
Allergies.....	____	____
Chemotherapy/radiation.....	____	____
Hospitalization for illness or injury	____	____
Surgery.....	____	____
Glaucoma.....	____	____
Problems of the immune system	____	____
Arthritis.....	____	____
Lupus.....	____	____
Psychiatric treatment.....	____	____
Thyroid problems.....	____	____
Stomach ulcers.....	____	____
Sinus problems.....	____	____
Asthma.....	____	____
Anemia.....	____	____
Heart valve replacement.....	____	____
Hip or knee replacement……..	____	____
HIV positive/AIDS.....	____	____
Kidney trouble.....	____	____

If female, are you now:	**Yes**	**No**
Pregnant.....	____	____
Are you nursing..... ...	____	____
through menopause.....	____	____
taking birth control pills....	____	____
Do you have/have you had Epilepsy/other **reaction to:**		
Latex.....	____	____
Aspirin, ibuprofen, Tylenol...	____	____
Local anesthetics.....	____	____
Penicillin or amoxicillin.....	____	____
Clindamycin..... .	____	____
~ Tetracycline or doxycycline…	____	____
~ Sulfa.....	____	____
~ Codeine or other narcotics…	____	____
~ other.....	____	____

Which _____

Have you taken any of the following within the past 5 years:

Fosomax, Actonel, Boniva…….	____	____
Anticoagulants/Aspirin.....	____	____
Steroids.....	____	____
Are you taking any medications	____	____

If so, what medicine(s) are you **taking**:
_____
_____
_____

Any serious illness not listed:_____
Have you had any serious trouble associated with any previous dental treatment: YES NO
If YES, explain: _____

I certify that I have read and understood 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 the dentist, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ Patient's Signature

_____ Doctor's Signature