WESTERN IOWA
PERIODONTICS &
IMPLANT DENTISTRY

Medical History

No	**?**	**Yes**	Allergy- Aspirin
No	**?**	**Yes**	Allergy- Codeine
No	**?**	**Yes**	Allergy- Latex
No	**?**	**Yes**	Allergy- Local anesthetic
No	**?**	**Yes**	Allergy- Penicillin
No	**?**	**Yes**	Allergy- Sulfa

List any other allergies:_____

No	**?**	**Yes**	Abnormal (High/Low) Blood Pressure
No	**?**	**Yes**	AIDS/HIV
No	**?**	**Yes**	Anemia/Bleeding Problems
No	**?**	**Yes**	Artificial Heart Valves
No	**?**	**Yes**	Congenital Heart Lesions
No	**?**	**Yes**	Heart Problems
No	**?**	**Yes**	Pacemaker
No	**?**	**Yes**	Arthritis/Rheumatism/Gout
No	**?**	**Yes**	Artificial Joints/Bones
No	**?**	**Yes**	Asthma
No	**?**	**Yes**	Cancer
No	**?**	**Yes**	Chemotherapy
No	**?**	**Yes**	Diabetes
No	**?**	**Yes**	Emphysema
No	**?**	**Yes**	Glaucoma
No	**?**	**Yes**	Radiation Treatment (Xray/Cobalt)
No	**?**	**Yes**	Shortness of Breath (breathing problems)
No	**?**	**Yes**	Sinus trouble
No	**?**	**Yes**	Stroke
No	**?**	**Yes**	Thyroid Problems
No	**?**	**Yes**	Tuberculosis
No	**?**	**Yes**	Tumor/growth on head/neck
No	**?**	**Yes**	Ulcer
No	**?**	**Yes**	Epilepsy
No	**?**	**Yes**	Fainting/Dizziness

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No	**?**	**Yes**	Headaches(frequent)
No	**?**	**Yes**	Hepatitis
No	**?**	**Yes**	Herpes
No	**?**	**Yes**	Kidney Disease
No	**?**	**Yes**	Liver Disease
No	**?**	**Yes**	Nervous Problems
No	**?**	**Yes**	Psychiatric Care

List any other medical issues you have:_____
List any other serious illnesses/surgeries/hospitalizations:_____
_____
List any **medications** you are taking:_____
_____
_____

No	**?**	**Yes**	Do you smoke?
No	**?**	**Yes**	Do you drink alcohol?
No	**?**	**Yes**	High Sugar intake?

No	**?**	**Yes**	Pregnant?
No	**?**	**Yes**	Nursing?

Signature:_____
Date:_____