NOVA Perio Specialists

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Patient Name:

Last First MI

Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Radiation/Chemo
- ☐ Seasonal Allergies
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ *Pre-Med - Clind
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Dementia
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tumors/Growths
- ☐ *Pre-Med - Other
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Diabetes Type I/II
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ Kidney transplant
- ☐ Lyme Disease
- ☐ Other
- ☐ Rheumatic Fever
- ☐ Smoker
- ☐ Sulfa
- ☐ Ulcers
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Dizziness/Fainting
- ☐ Head/Neck/Jaw Injury
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Latex Allergy
- ☐ Mental Disorders
- ☐ Pacemaker/Stents
- ☐ Rheumatism
- ☐ STD/HPV
- ☐ Thyroid Disease

☐ Pregnant/Planning Pregnancy/Nursing ☐ No Medical Conditions

☐ No Health Changes

Please clarify the conditions or alerts selected including due date if pregnant:

Do you take antibiotic premedication for your dental visits? If yes, please explain. * Pre-Med ○ Yes ○ No

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy

Are you taking any medications (prescription and Non-prescription) if yes please explain below * Medications

○ Yes ○ No

Do you have any allergies and/or allergies to medications. If yes, please explain below * Allergies

○ Yes ○ No

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.**

Name of Patient/Parent or Guardian completing this form *

Response Date: _____