



# Anna M. Munné, D.D.S., P.A.

Periodontics • Implants

*Diplomat of the American Academy of Periodontology*

## PATIENTS MEDICAL HISTORY

Date \_\_\_\_\_ Patient Name \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ D/O/B \_\_\_\_\_ Age \_\_\_\_\_

Do you smoke? Yes No Have you ever smoked?  Yes  No  Quit: When? \_\_\_\_\_  
\_\_\_\_cigarettes \_\_\_\_pipe \_\_\_\_chewing \_\_\_\_cigar \_\_\_\_snuff How much per day? \_\_\_\_\_

Alcohol use  Yes  No How many? \_\_\_\_\_ Day/ Week

Recreational drugs?  Yes  No Type \_\_\_\_\_ Frequency \_\_\_\_\_

Do you need pre-medication prior to a dental appointment? Y N Antibiotic used? \_\_\_\_\_

### Current/Past Diseases:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Heart pacemaker       | <input type="checkbox"/> Chemotherapy      | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Attack      |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Thyroid disease    | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> Heart surgery         | <input type="checkbox"/> Liver disease     | <input type="checkbox"/> Implant prosthesis | <input type="checkbox"/> Hypertension      |
| <input type="checkbox"/> Psychiatric care      | <input type="checkbox"/> Jaundice          | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Frequent chest pains  | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Cholesterol  |
| <input type="checkbox"/> Lupus erythematosus   | <input type="checkbox"/> Ulcers-gastritis  | <input type="checkbox"/> Lung disease       | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Dizzy spells      | <input type="checkbox"/> Hives/skin rash    | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Kidney disease    | <input type="checkbox"/> Ankle swelling     | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Substance abuse       | <input type="checkbox"/> Convulsions       | <input type="checkbox"/> Venereal diseases  | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> AIDS/HIV+         | <input type="checkbox"/> Cortisone therapy  | <input type="checkbox"/> Bruise Easily     |
| <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Osteopenia        | <input type="checkbox"/> _____              | <input type="checkbox"/> _____             |

Diseases in your family \_\_\_\_\_

### Prescription Medication

### Non- Prescription Medication

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken Fosamax, Actonel, or Boniva?  Yes  No When did you start? \_\_\_\_\_

How long was it taken? \_\_\_\_\_ Date finished: \_\_\_\_\_

Last Physical Exam \_\_\_\_\_ Physicians Name: \_\_\_\_\_

**Allergies to:**

Prescription Drug Allergies: \_\_\_\_\_

Non-Prescription Drug Allergies: \_\_\_\_\_

Surgical History w/ dates: \_\_\_\_\_

General Anesthesia Complications:  Yes  No If Yes, Please Explain: \_\_\_\_\_

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**FOR WOMEN ONLY**

Are you pregnant now?  Yes  No Trimester 1 2 3

Taking hormones/ birth control? \_\_\_\_\_

Have you reached menopause?  Yes  No Have you had a hysterectomy?  Yes  No

Are you anticipating pregnancy?  Yes  No Are you breastfeeding?  Yes  No

Gave birth to \_\_\_\_\_ children, ages \_\_\_\_\_

Did you have any complications during pregnancy?  
\_\_\_\_\_

Do you experience frequent yeast infections?  Yes  No

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Do you have any other disease, condition or problems not listed above that Anna Munne, DDS, PA should know about before proceeding with treatment? \_\_\_\_\_

<b>I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.</b>	
<b>SIGNATURE</b>	<b>DATE</b>
X _____	_____
X _____	_____
X _____	_____