

GLENN S. LUDWIG, D.M.D., P.C.

Medical History:

Date _____

Name _____ Date of Birth _____ Age _____

Occupation _____ Spouse's Name _____

Home Address _____

_____ Zip Code _____ Home Telephone No. _____

Business Address _____

_____ Zip Code _____ Business Telephone No. _____

Which telephone would be best for messages? _____

How did you first learn of your need for our services? _____

What made you select this office? _____

Your Dentist's Name _____

Address _____

_____ Zip Code _____ Telephone No. _____

Your Physician's Name _____

Address _____

_____ Zip Code _____ Telephone No. _____

Date of last medical examination _____

Name of parent (if minor) _____

Address _____

_____ Zip Code _____ Telephone No. _____

What dental and major medical insurance do you have? _____

Social Security or Insurance I.D. number _____

What is your present problem and what would you like to have handled today? _____

PLEASE WRITE BRIEF ANSWER IF APPROPRIATE

YES NO DK*

1. Do you consider yourself to be in good health? _____
2. Are you under the care of a physician? _____
3. Have you had any illnesses, operations or been hospitalized? _____
4. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? _____
5. Do you have a prosthetic replacement that requires premedication (i.e. knee, hip, wrist, leg)? _____
6. Have you ever had rheumatic heart disease, rheumatic fever or tuberculosis? _____
7. Do you have a heart valve replacement or vascular graft? _____
8. Have you ever been told you have mitral valve prolapse or a heart murmur? _____
9. Have you ever been told by a doctor that you have high or low blood pressure? _____
10. Have you ever been told by a doctor that you have heart trouble? _____
11. Do you have a cardiac pacemaker? _____
12. Do you have asthma? _____
13. Have you ever had chronic sinus infections? _____
14. Have you ever received treatment for any type of endocrine disorder (i.e. thyroid)? _____
15. Do you have or has anyone in your family had diabetes? _____
16. Did a doctor ever tell you that you had kidney or bladder trouble? _____
17. Do you have swollen ankles, arthritis or joint disease? _____
18. Have you ever tested positive for an autoimmune disease? _____
19. Has a doctor ever told you that you have stomach ulcers or stomach trouble? _____
20. Have you ever been treated for jaundice, hepatitis or liver disease? _____
21. Have you ever had abnormal bleeding following a cut or dental extraction? _____
22. Have you ever been treated for anemia? _____
23. Do you bruise easily? _____
24. Have you ever received chemotherapy or radiation therapy? _____
25. Has a doctor ever told you that you have osteoporosis? _____
26. Are you on any special type of diet? _____
27. Have you ever had severe pains of the face or head? _____
28. Do you consider yourself nervous? _____
29. Do you smoke cigarettes, cigars, or a pipe? _____
30. Are you taking any medications?
If so, please list: _____
31. Do you take a daily aspirin? _____
32. Have you ever taken cortisone? _____
33. Are you allergic to or had a reaction to any medication? (aspirin, Ibuprofen, Codeine, Penicillin, Tetracycline, Sulfa, Other: _____) _____
34. Do you have a latex allergy? _____
35. (Women) Do you take birth control pills? _____
36. (Women) Are you pregnant? _____
37. (Women) Have you ever had hormone replacement therapy? _____
38. (Women) Do you have any unusual hormonal or gynecological difficulties? _____
39. Are you taking or have you ever taken bisphosonates? _____

*DK - Don't Know

Signature