-Emil W. Tetzner, D.M.D., M.S.
Practice Limited to Periodontics

Name_____ Date_____
Street_____ Employer_____
City & State _____ Zip Code_____ Occupation_____
Home Phone_____ Social Security Number_____
Business Phone_____ General Dentist _____
Cell_____ Referred By_____
E-Mail _____ Physician_____
Birth Date _____M____F_____ Marital Status_____
Height_____ Weight_____ Spouse or Parent's Name_____
Emergency Contact_____ Spouse or Parent's Occupation_____
Emergency Contact Phone_____ *Dental Insurance* _____
*Pharmacy*_____

UPDATED MEDICAL HISTORY

Note to patient: These questions are for your benefit. This information will assist us in your diagnosis and treatment. Please check any of the following that apply to you:

_____ Dementia ____ Joint Replacement Date of Replacement _____

_____ Alzheimer's
_____ Heart trouble ____ Diabetes ____ Tuberculosis ____ Congenital Heart trouble
_____ Jaundice ____ Kidney Disease ____ Heart Murmur\Echo ____ Hepatitis
_____ Arthritis ____ Heart Surgery ____ Cancer ____ Stomach Ulcers
_____ Rheumatic Fever ____ Glaucoma ____ Stroke ____ Cardiac Pacemaker
_____ Sinus Trouble ____ Epilepsy ____ Persistent Cough ____ Heart Valve Prosthesis
_____ Psychiatric Care ____ High Blood Pressure ____ Asthma ____ Child Births
_____ HIV infection ____ Low Blood Pressure ____ Blood Transfusion ____ Thyroid Disorder
_____ Alcohol/Drug addiction ____ High Cholesterol ____ Sexually Transmitted Diseases

1. Have you had a recent complete physical examination? _____ When? _____
2. Has there been any change in your general health in the last year? _____
   Explain_____
3. Have you been under a doctor's care, been hospitalized or seriously ill during the past two years? ___ Explain: _____
4. Do you take any medications or drugs, including aspirin, vitamins, hormones, antacids, steroids or birth control pills presently or within the last six months? Please list below.

DRUG	DOSE & FREQUENCY
_____	_____
_____	_____
_____	_____

5. Are you allergic to or have you experienced an unusual reaction to drugs? _____
   Please list? _____
6. Have you experienced any other allergic reactions? Please list: _____
7. Have you experienced excessive bleeding that required special treatment? _____
8. Have you ever pre-medicated for a dental appointment? _____Do you pre-medicate now?_____
   Explain: _____
9. Do you smoke cigarettes? _____ Cigars? _____ Pipe? _____ How many per day? _____
   For how long? _____
10. Last Dental cleaning: _____

Women

11. Are you pregnant? _____Due date? _____Is your menstrual cycle regular? _____
12. Have you reached menopause? _____
13. Are you having any menopause symptoms? _____Please list: _____

SIGNATURE_____Date_____