BARRY E. WOOTTON, D.D.S., INC.
ANA J. AMAYA, D.D.S., M.S.

PATIENT HISTORY AND INFORMATION

Name _____ Today's Date_____ Age_____ Birth Date_____ Marital Status____

Address _____ City_____ Zip_____ Phone _____

Occupation_____ Employed By_____

Business Address_____ City_____ Zip_____ Phone _____

Name of Spouse _____ Spouse Employed By_____

Occupation _____ Business Address_____ Phone_____

Name of Dentist _____ City_____ How Long?_____

Name of Physician _____ City_____ Last Physical_____

Referred to this office by_____

What is your reason for seeking periodontal care? _____

Do you have dental insurance? ☐ Yes ☐ No

Primary Carrier Insurance Co.

_____

Address _____

City, State, Zip _____

Employee _____ Birthdate_____

Group No. _____ Soc. Sec. No._____

Secondary Carrier Insurance Co.

_____

Address _____

City, State, Zip _____

Employee_____ Birthdate_____

Group No._____ Soc. Sec. No._____

MEDICAL HISTORY

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

Please Circle "Yes" or "No" to Each Item

NOTES

1. Do you consider yourself to be in good health? YES ☐ NO ☐
2. Are you being treated by a physician now? YES ☐ NO ☐
   If so, what for? _____
3. Are you taking **any** drugs or prescribed medication? YES ☐ NO ☐
   Please list *(Include Birth Control)*_____
   _____
4. Have you been hospitalized or had surgery within the last five years? YES ☐ NO ☐
   If yes, what for?_____
5. Indicate which of the following you have had or have at present. **Circle "Yes" or "No" EACH ITEM.**

Heart Failure	YES NO	Artificial Joints (hip, knee, etc.)	YES NO	Hepatitis B (Serum)	YES NO
Heart Disease or Attack	YES NO	Kidney Trouble	YES NO	Venereal Disease	YES NO
Angina Pectoris	YES NO	Ulcers	YES NO	AIDS	YES NO
Congenital Heart Disease	YES NO	Diabetes	YES NO	H.I.V. Positive	YES NO
Heart Murmur	YES NO	Thyroid Problems	YES NO	Cold Sores/Fever Blisters	YES NO
High Blood Pressure	YES NO	Glaucoma	YES NO	Blood Transfusion	YES NO
Arteriosclerosis	YES NO	Cosmetic Surgery	YES NO	Hemophilia	YES NO
Mitral Valve Prolapse	YES NO	Emphysema	YES NO	Anemia	YES NO
Artificial Heart Valve	YES NO	Chronic Cough	YES NO	Sickle Cell Disease	YES NO
Heart Pacemaker	YES NO	Tuberculosis	YES NO	Bruise Easily	YES NO
Heart Surgery	YES NO	Asthma	YES NO	Liver Disease	YES NO
Rheumatic Fever	YES NO	Hay Fever	YES NO	Yellow Jaundice	YES NO
Arthritis	YES NO	Allergies or Hives	YES NO	Epilepsy or Seizures	YES NO
Rheumatism	YES NO	Sinus Trouble	YES NO	Fainting or Dizzy Spells	YES NO
Cortisone Medicine	YES NO	Radiation Therapy	YES NO	Nervousness	YES NO
Drug Addiction	YES NO	Chemotherapy	YES NO	Psychiatric Treatment	YES NO
Stroke	YES NO	Hepatitis A (infectious)	YES NO	Developmentally Disabled	YES NO

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO
   If yes, please list: _____

NOTES

7. Do you consider yourself to be under mental or emotional stress? YES ☐ NO ☐
8. Have you ever had excessive bleeding requiring special treatment? YES ☐ NO ☐
9. Do you have frequent colds or sinus trouble? YES ☐ NO ☐
10. Do you have frequent headaches? YES ☐ NO ☐
11. Do injuries or cuts heal very slowly? YES ☐ NO ☐
12. Do you have shortness of breath with mild exertion? YES ☐ NO ☐
13. Do your ankles ever swell? YES ☐ NO ☐
14. Do you smoke? How many packs per day?_____ YES ☐ NO ☐
15. Have you ever had x-ray treatment for a tumor? YES ☐ NO ☐
16. Are you on a special diet or restricted diet now? YES ☐ NO ☐
    Why?_____
17. Do you have or have you had any disease, condition or problem not listed? YES ☐ NO ☐
    If yes, please list: _____
    _____

FOR WOMEN ONLY:

18. Are you pregnant? If yes, what month?_____ YES ☐ NO ☐
19. Are you nursing? YES ☐ NO ☐
20. Are you taking birth control pills? YES ☐ NO ☐
21. Are you menopausal? YES ☐ NO ☐

DENTAL HISTORY

1. Are you experiencing discomfort from your mouth at this time? YES ☐ NO ☐
2. Date of last dental appointment_____
   What was done?_____
3. How often have you had your teeth cleaned in the past five years? _____
   When was your most recent cleaning?_____
4. Have you had previous periodontal (gum) treatment? YES ☐ NO ☐
   If so, when? _____
5. Do your gums ever bleed when you brush or floss? YES ☐ NO ☐
6. Have you noticed any loose teeth or change in your bite? YES ☐ NO ☐
7. Do you have difficulty chewing on either side of your mouth? YES ☐ NO ☐
8. Are you dissatisfied with the appearance of your teeth? YES ☐ NO ☐
9. Have you noticed any mouth odors or bad tastes? YES ☐ NO ☐
10. Do you often develop cold sores or other oral lesions? YES ☐ NO ☐
11. Are any of your teeth generally sensitive to heat, cold, chewing or sweets? YES ☐ NO ☐
12. Are you aware of grinding or clenching your teeth? YES ☐ NO ☐
13. When you chew, do you have clicking, popping, or pain in your jaw joints? YES ☐ NO ☐
14. Have you ever been treated for pain in the jaw joints? YES ☐ NO ☐
15. Have you ever had orthodontic treatment (braces)? YES ☐ NO ☐
16. How often do you brush your teeth?_____
    What type of toothbrush? ☐Hard ☐Medium ☐Soft
17. Do you use dental floss or toothpicks between your teeth? YES ☐ NO ☐
    How often? _____
18. Rate the importance you place upon keeping your remaining natural teeth:
    1☐ 2☐ 3☐ 4☐ 5☐
    Extremely Important — Not Important
19. Are you apprehensive about dental treatment? YES ☐ NO ☐
    If so, what is your biggest fear?_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date_____