

Practice Limited to Periodontics
Dental Implantology

Patient Information (All Information is confidential)

Name: _____
(Last) (First) (Middle)

Marital Status: (check) Single Married Divorced Widowed Separated

Date of Birth: _____ Sex: _____ Height _____ Weight _____ Occupation _____

Person to contact in case of emergency: _____ Phone: _____

Referred by: _____ How long his/her patient _____

Medical Health (The information contained herein is considered confidential and is for our records only.)

General health (please check) Excellent Good Fair Poor Last Complete Physical _____

Name of physician: _____ Specialty: _____
City: _____ State: _____ Phone: _____

Name of physician: _____ Specialty: _____
City: _____ State: _____ Phone: _____

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City: _____ State: _____ Phone: _____

Health History

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last Medical Exam: _____ Date of last dental appt: _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

- | | |
|---|-----------------------------------|
| 7. Yes No Chest Pain (angina)? | 18. Yes No Dizziness? |
| 8. Yes No Swollen ankles? | 19. Yes No Ringing in the ears? |
| 9. Yes No Shortness of breath? | 20. Yes No Headaches? |
| 10. Yes No Recent weight loss, fever, night sweats? | 21. Yes No Fainting spells? |
| 11. Yes No Persistent cough, coughing up blood? | 22. Yes No Blurred vision? |
| 12. Yes No Bleeding problems, bruising easily? | 23. Yes No Seizures? |
| 13. Yes No Sinus problems? | 24. Yes No Excessive thirst? |
| 14. Yes No Difficulty swallowing? | 25. Yes No Frequent urination? |
| 15. Yes No Diarrhea, constipation, blood in stools? | 26. Yes No Dry mouth? |
| 16. Yes No Frequent vomiting, nausea? | 27. Yes No Jaundice? |
| 17. Yes No Difficulty urinating, blood in urine? | 28. Yes No Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|--|--------------------------------------|
| 29. Yes No Heart disease? | 40. Yes No HIV or AIDS? |
| 30. Yes No Heart attack, heart defects? | 41. Yes No Tumors, cancer? |
| 31. Yes No Heart murmurs? | 42. Yes No Arthritis, rheumatism? |
| 32. Yes No Rheumatic fever? | 43. Yes No Eye disease? _____ |
| 33. Yes No Stroke, hardening of arteries? | 44. Yes No Skin diseases? _____ |
| 34. Yes No High blood pressure? | 45. Yes No Anemia? |
| 35. Yes No TB, emphysema, lung diseases? | 46. Yes No STD? |
| 36. Yes No Hepatitis, other liver disease? | 47. Yes No Herpes? |
| 37. Yes No Stomach problems, ulcers? | 48. Yes No Kidney, bladder disease? |
| 38. Yes No Allergies to: drugs, foods, medications? _____ | 49. Yes No Thyroid, adrenal disease? |
| 39. Yes No Family history of diabetes, heart problems, tumors? | 50. Yes No Diabetes? Type _____ |

- 51. Yes No Psychiatric care?
- 52. Yes No Radiation treatments?
- 53. Yes No Chemotherapy?
- 54. Yes No Prosthetic heart valve?
- 55. Yes No Artificial joint?
- 56. Yes No Bronchitis or Asthma?

- 57. Yes No Hospitalization?
- 58. Yes No Blood transfusions?
- 59. Yes No Surgeries?
- 60. Yes No Pacemaker?
- 61. Yes No Contact lenses?
- 62. Yes No Osteoporosis?

IV. ARE YOU TAKING:

- 63. Yes No Recreational drugs?
- 64. Yes No Drugs, medicines, (incl. Aspirin)?

- 65. Yes No Tobacco in any form?
- 66. Yes No Alcohol?

Please List: _____

V. WOMEN ONLY:

- 67. Yes No Are you or could you be pregnant or nursing?

- 68. Yes No Taking birth control pills?

VI. ALL PATIENTS

- 69. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

Dental Health

Reason for visit: _____

When was your last dental visit? _____ Last cleaning? _____

Have you ever had any serious problem associated with previous dental treatment?..... Yes No

If so, explain: _____

How often do you brush your teeth? _____

What texture brush do you use? Soft Medium Hard

How often do you floss? _____

Do your gums bleed while brushing?..... Yes No

Do your gums bleed when flossing?..... Yes No

Do you avoid brushing any part of your mouth because of pain?..... Yes No

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

- a) hot food or liquids, i.e., soup, coffee, tea, etc.?..... Yes No
- b) cold foods or liquids, i.e., ice cream, cold fruit, etc.?..... Yes No
- c) sweets, i.e., candy, fruit, sweet desserts, etc.?..... Yes No
- d) sours, i.e., lemons, limes, grapefruit, etc.?..... Yes No

Do you smoke? If yes, how much? _____

Do you use chewing tobacco? if yes, how much? _____

Do you feel pain to any of your teeth when brushing or flossing them?..... Yes No

Do you chew on only one side of your mouth?..... Yes No

If yes, explain: _____

Do your gums feel tender or swollen?..... Yes No

Do you clench or grind your jaws while sleeping or during the day?..... Yes No

Do your jaws ever feel tired?..... Yes No

Do you think your teeth are moving or drifting?..... Yes No

Are you familiar with the term periodontal disease?..... Yes No

Have you ever been told that you had periodontal disease?..... Yes No

Have you ever been treated for periodontal disease?..... Yes No

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Patient signature: _____ Date: _____