Periodontics

Date ____________________

Name	Date of Birth	Email

Occupation	Telephone (Home)	(Cell)	(Work)

Last Medical Examination	Blood Taken?	Findings	Physician(s) Name & Telephone

General Dentist	Have Family or Friends Been Treated Here?

PRESENT DENTAL COMPLAINTS

DENTAL HISTORY

	Yes	No
Do you fear dental treatment		
Have you ever been treated for periodontal disease		
Have you ever had trench mouth		
Do your gums bleed		
Do you have difficulty chewing your food		
Do you grind or clench your teeth		
Do you have a bite guard/splint		
Are spaces developing between your teeth		
Have you noticed your bite changing		
Are you aware of breath odor		
Do you have frequent cold/canker sores		
Do you frequently breathe through your mouth		
Do you have pain in the jaw joints (TMJ)		
Have you ever had orthodontic treatment to straighten your teeth		
Have you ever had problems with extractions		
Does food wedge between your teeth		
Has any member of your family lost all their teeth		
Would you be tremendously disturbed to lose all of your teeth		
Are you having pain or discomfort at this time		

When was your last dental cleaning ____________________

How often have your teeth been cleaned in the past 3 years ______

How long have you been a patient of your present dentist ________

How long have you known about your gum condition ___________

Are your teeth sensitive to: Hot _____ Cold _____ Sweet ____

Have you had any “gum boils” or gum swelling Yes ___ No___

Are you satisfied with the appearance of your teeth Yes ___ No ___

If no, why not ______________________________

How would you rate your past dental care ________________

Do you desire nitrous oxide during treatment ________________

Are you available on short notice for appointments Yes ___ No ___

Please check any of the following items used in mouth care:

Hand toothbrush............. _______

Type ______________________________

Electric toothbrush........... _______

Type ______________________________

Proxabrush...................... _______

Dental floss .... _______

Floss holder..................... _______

Mouthwashes.................. _______

Type ______________________________

Water spray device .. ______

Toothpicks............... ______

Perio Aid.................. ______

Stimudents.............. ______

Gum stimulator .... ______

Rubber tip .... ______

Toothpaste type .... ______

Other____________________

DENTAL HISTORY NOTES..

HEALTH HISTORY UPDATE

Date .... Reviewer .... Changes	Date .... Reviewer .... Changes	Date .... Reviewer .... Changes ....
Date .... Reviewer .... Changes	Date .... Reviewer .... Changes	Date .... Reviewer .... Changes ....
Date .... Reviewer .... Changes	Date .... Reviewer .... Changes	Date .... Reviewer .... Changes ....
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B.P.	Pulse

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
Heart attack or stroke		
Arteriosclerosis		
Angina pectoris (Chest pain)		
Shortness of breath		
Swelling in ankles		
High or low blood pressure		
Heart murmur or valve problem		
Rheumatic fever		
Artificial heart valve		
Heart pacemaker		
Abnormal bleeding problems		
Anemia or blood disorder		
Diabetes		
Or family history of		
Hepatitis, jaundice or liver disease		
Thyroid or parathyroid disease		
Stomach or duodenal ulcers		
Kidney disease or infection		
Seizure Disorder (Epilepsy), convulsions or fainting spells		
Glaucoma		
Osteoporosis or osteopenia		
Medication for osteoporosis/osteopenia ______________		
Arthritis or rheumatism		
Artificial joint replacement		
Orthopedic screws, pins, etc.		
Emphysema or chronic bronchitis		
Tuberculosis		
Asthma, hay fever or allergies		
Hives or skin rash		
Allergic to dental anesthetic		
Drug reaction to codeine, tetracycline, penicillin, Demerol, valium, erythromycin, percocet, nitrous oxide, percodan, barbiturates, aspirin, other __________________________		
HIV or AIDS		
AIDS antibody (HIV or HTLV_III) positive		
Venereal disease		
Herpes		
Cancer or abnormal growth		
Radiation or chemotherapy		
Surgery		
Hospitalization for illness or surgery (list below)		

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
Anticoagulants (blood thinners)		
Do you bruise easily		
Blood transfusion		
Cortisone medication		
Prostate trouble		
Alcoholism		
Drug addiction		
Eating disorder (anorexia, bulimia, etc.)		
Depression		
Any serious illness, disease, condition, not listed (list below)		

ARE YOU:	YES	NO
Presently under a physicians care		
Taking any medication now (list below)		
Or within past year		
Taking vitamins		
Taking herbal supplements or over-the-counter medications (list below)		
Recent unexplained weight change of (10 lbs+)		
Often exhausted or fatigued		
Subject to frequent headaches		
A nervous person		
Under unusual stress		
Taking medication for anxiety/depression		
Taking sleeping medication		
Undergoing psychotherapy		
Do you wear contact lenses		
Do you currently use tobacco products		
Have you used tobacco products in the past		

Type ______________________________________

Amount ___________________________________

IF FEMALE, are you now (please check if yes)

Pregnant _______ Nursing _______

Anticipate becoming pregnant ______

Presently in (or post) menopause ___________

Taking oral contraceptives ______

Hormone Replacement Therapy ______

MEDICAL HISTORY NOTES..

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To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor or his/her staff at the next appointment without fail.

DATE: ________________________________

PATIENT'S SIGNATURE____
(Guardian/Parent if minor)