

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

III. DO YOU HAVE OR HAVE YOU HAD:

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



