ARIEL E. TRUJILLO, DMD

Practice Limited to Periodontics
Dental Implantology

ARIZONA Periodontal GROUP

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: _____

Diagnosis and Treatment Plan

Name:

Clinical Examination

Blood pressure: ______________________ Medication: ______________________

Soft tissues of head and neck: ______________________

Oral mucosa: ______________________

Teeth: ______________________

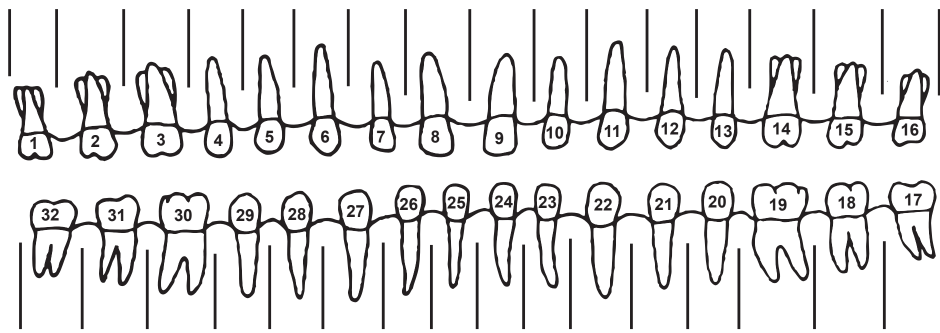
Gingiva: ______________________

Occlusion: ______________________

TMJ: ______________________

Oral hygiene: ______________

Perio Type: ______________



Name:

Treatment Record

Date	Tooth Quad	Procedure	Initial

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