MEDICAL AND DENTAL HISTORY:

PERIODONTAL DISEASE IS CAUSED BY A COMBINATION OF COMPLEX FACTORS. THE FOLLOWING QUESTIONS ARE DESIGNED TO HELP US IDENTIFY THEM. ALTHOUGH SOME OF THE QUESTIONS MAY SEEM UNRELATED TO YOUR PERIODONTAL CONDITION, THEY ARE ASSOCIATED WITH PROPER MANAGEMENT OF YOUR PHYSICAL AND ORAL HEALTH.

MEDICAL PHYSICIANS' NAME:_____ PHONE#_____

PHYSICIAN'S ADDRESS: _____

DATE AND REASON FOR LAST PHYSICAL EXAMINATION: _____

_____

_____

PLEASE CIRCLE YES (Y) OR (NO) FOR THE FOLLOWING QUESTIONS:

Are you under the care of a physician?.....Y N
Have you been hospitalized or had
a serious illness in the last 5 years?.....Y N
Are you currently on any medications or drugs?.....Y N
If yes, please list: _____

_____

_____

Do you consider yourself in good health?.....Y N
Are you aware of being allergic to or have you ever
reacted adversely to any medication or substance?.....Y N
If yes, please list: _____
Have you ever had major surgery?.....Y N

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?
(IF YES – PLEASE CIRCLE WHICH APPLIES):

Rheumatic or scarlet fever?.....Y N
Heart problems/attack/stroke?.....Y N
High/Low blood pressure?.....Y N
Heart Murmur?.....Y N
Blood or Clotting disorders?.....Y N
H. I. V. Positive/A.I.D.S?.....Y N
Hepatitis A., B., C.?.....Y N
Thyroid/parathyroid disorders?...Y N
Frequent headaches?.....Y N
Tumor or growth?.....Y N
Tuberculosis/emphysema?.....Y N
Do you bruise easily?.....Y N
Latex Allergy?.....Y N

Tendency to faint?.....Y N
Diabetes?.....Y N
Kidney Problems?.....Y N
Ulcers?.....Y N
Epilepsy/Convulsions?.....Y N
Are you pregnant?.....Y N
Anemia?.....Y N
Asthma/hives/hayfever?.....Y N
Arthritis/rheumatism?.....Y N
Venereal disease?.....Y N
Radiation therapy?.....Y N
Artificial joints?.....Y N

DATE OF MOST RECENT DENTAL CLEANING?_____
WHO REFERRED YOU TO OUR OFFICE?_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Bleeding gums?.....Y N
Receding gums?.....Y N
Sensitive teeth?.....Y N
Previous gum treatment?.....Y N
Previous braces (ortho)?.....Y N
Tooth grinding/Clenching?.....Y N

Chew on one side?.....Y N
Concern about losing teeth?.....Y N
Shifting or loose teeth?.....Y N
Complications with previous
dental treatment?.....Y N
TMJ (Jaw) Pain?.....Y N

I AM ULTIMATELY RESPONSIBLE FOR FULL BILLED AMOUNT, REGARDLESS OF INSURANCE STATUS.

Signature_____ **Date**_____