PLEASE PRINT AND ANSWER ALL QUESTIONS, INITIAL BOTTOM OF EACH PAGE AND SIGN THE LAST PAGE. ALL INFORMATION PROVIDED IS CONFIDENTIAL.

Name (Dr/Mr/Mrs/Ms)_____Age_____Birthdate_____Height _____Weight_____
(Please Circle) Single Married Separated Divorced Widowed Partner
Residence Address_____City_____Zip_____ Phone_____
Business Address_____City_____Zip_____ Phone_____
Home Fax _____ Office Fax _____ Cell Phone _____
Occupation _____Position _____ Employer_____
Name of Spouse_____
Occupation _____Position _____Employer _____
Party Responsible for Payment _____Relation to You_____
Emergency Contact Other Than Spouse _____ Phone _____
Referred By _____City _____ Phone _____
Current Dentist _____City _____ How Long? _____ Frequency? _____
Previous Dentist _____City _____ How Long? _____ Frequency? _____
Your Physician _____How Long? _____
Physician's Address _____City _____Phone _____
Date of Last Complete Physical Examination _____Purpose of Exam _____
Findings _____

GENERAL HEALTH: (Please circle 'Yes' or 'No'; If in doubt circle 'U', and fill in other information asked for)

Yes No U 1. Are you presently under the care of a physician? If so, why?_____
Yes No U 2. Do you have any type of health problem? If so, what? _____
Yes No U 3. Do you have any type of heart problem? If so, what? _____
Yes No U 4. Do you have high or low blood pressure? If so, which? _____
Yes No U 5. Do you have shortness of breath after climbing one flight of stairs?
Yes No U 6. Do you bleed for more than 30 minutes after a minor cut or have any other minor bleeding problems? If so, what? _____
Yes No U 7. Are you taking any medications or drugs including aspirin, vitamins, recreational drugs? List each drug, reason and who prescribed the drug. (Use back of page if more space is needed) _____
_____
Yes No U 8. Have you ever taken medication for osteoperosis/osteopenia? If so, what?_____
Yes No U 9. Have you been hospitalized in the last 10 years? If so, for what? _____
Yes No U 10. Do you faint easily?
Yes No U 11. Have you taken cortisone or steroids in the last 6 months? _____
Yes No U 12. Have you been under the care of a physician in the last 2 years other than for a routine physical? If so, for what? _____
Yes No U 13. Have you had any major illness or serious operation in the last 10 years? If so, describe: _____
_____
Yes No U 14. Do you have any kidney or liver problems? If so, describe:_____
Yes No U 15. Have you had rheumatic fever? If so, when was it first diagnosed? _____
Yes No U 16. Do you have any type of artificial valve, joint pin, prosthetic hip, etc, in place now?
Yes No U 17. Do you have a heart murmur, mitral valve prolapse or heart click?
Yes No U 18. Have you ever received psychiatric care or psychotherapy? If so, which? _____
Yes No U 19. Have you ever tested positive for Tuberculosis?
Yes No U 20. Do you now or have you ever had Hepatitis? If so, when? _____
Yes No U 21. Do you have AIDS or AIDS-Related Complex (ARC) or ever tested positive for the AIDS virus?

Please circle each of the following medications to which you are allergic:

Acetaminophen	Aspirin	Carbocaine	Codeine	Demerol	Doxycycline	Duranest
Erythromycin	Halcion	Iodine	Keflex/Keflin	Latex	Morphine	Novacaine
Penicillin	Percodan	Phenaphen	Phenergan	Sulfa	Stadol	Tetracycline
Tylenol	Valium	Versed	Xylocaine			

List All Others: _____

Date_____ **Patient's Initial (or Parent/Guardian if under 18 years old) _____**

MEDICAL HISTORY: DO YOU NOW OR HAVE YOU EVER HAD:

Yes No U 1. Anemia?
Yes No U 2. Frequently swollen ankles?
Yes No U 3. Stomach ulcers, diverticulitis, or ulcerative colitis?
Yes No U 4. Excessive thirst or hunger over an extended period of time?
Yes No U 5. The need to get up nightly to urinate?
Yes No U 6. Cuts that tend to heal slowly?
Yes No U 7. Diabetes? If so, how is it treated? _____
Yes No U 8. Hemophilia?
Yes No U 9. Implant or transplant? If so, describe. _____
Yes No U 10. Thyroid disturbance or taken thyroid tablets?
Yes No U 11. Tuberculosis or emphysema?
Yes No U 12. Kidney or bladder disease?
Yes No U 13. Arthritis or rheumatism?
Yes No U 14. Venereal disease (syphilis, gonorrhea, herpes II)?
Yes No U 15. Epilepsy, convulsions, or seizures?
Yes No U 16. Cancer or radiation therapy?
Yes No U 17. Do you smoke or use tobacco in any form? If so, type and frequency? _____
Yes No U 18. Did you know that if you smoke, you have more problems with gum diseases and their treatment and have a higher risk of losing dental implants and/or natural teeth?
Yes No U 19. Do you wear contact lenses?
Yes No U 20. Are you taking any sort of tranquilizers?
Yes No U 21. Are you taking anticoagulants (blood thinners)?
Yes No U 22. Are you taking antacids regularly? If so, what? _____
Yes No U 23. Are you taking mood elevators?
Yes No U 24. Do you have glaucoma?
Yes No U 25. Do you have asthma, hay fever or eczema?
Yes No U 26. Do you have liver problems?
Yes No U 27. Have you ever had Botox® or dermal fillers (e.g. Juvederm®)?
Yes No U 28. Do you have prostate problems (males only)?

MEDICAL HISTORY (FEMALES ONLY)

Yes No U 29. Are you pregnant?
Yes No U 30. Have you had a hysterectomy or ovariectomy?
Yes No U 31. Are you taking birth control pills?
Yes No U 32. Have you been through menopause?
Yes No U 33. Have you had a miscarriage?

FAMILY HISTORY

Yes No U 1. Have any of your blood relatives had heart disease or high blood pressure?
Yes No U 2. Have any of your blood relatives had diabetes?
Yes No U 3. Have any of your blood relatives lost teeth as a result of gum disease? If so, who? _____
Yes No U 4. Have we treated any of your relatives? If so, who? _____

**Do you have any disease, medical condition, or health problem not listed above that you think we should know about or that you believe might affect treatment in any way?

_____
_____
_____

**Do you have any questions before the examination? If so, what (use back of page if needed)?

_____
_____
_____

Date_____ **Patient's Initial (or Parent/Guardian if under 18 years old) _____**

DENTAL HISTORY

1. How would you describe your dental health? **EXCELLENT GOOD FAIR POOR**
2. What do you do to clean your teeth at home? Brush _____ How Often? _____
   Floss _____ How Often? _____ Other (Bridge Cleaners, Stimudents, Rubber Tip, etc.)
   List and describe frequency: _____

Yes No U 3. Type of toothbrush used: **HARD MEDIUM SOFT MANUAL MECHANICAL**
Yes No U 4. Have you had personal instruction in oral hygiene? By whom and when? _____
Yes No U 5. Do you feel your present oral hygiene is effective in cleaning your mouth?
Yes No U 6. Have you ever had orthodontic treatment (braces)?
Yes No U 7. Are you satisfied with the way your teeth and gums look?
8. If unsatisfied, what would you wish to change? _____
Yes No U 9. Can you chew satisfactorily?
Yes No U 10. Have you noticed spaces developing between your teeth? When did this begin? _____
Yes No U 11. Are your gums receding? If so, where? _____
Yes No U 12. Are your teeth sensitive to hot? If so, which ones? _____
Yes No U 13. Are your teeth sensitive to cold? If so, which ones? _____
Yes No U 14. Are you aware that sensitivity of the teeth to cold can be caused by grinding?
Yes No U 15. Do you clench your teeth? If so, when? _____
Yes No U 16. Do you grind your teeth? If so, when? _____
Yes No U 17. Have you noticed your bite changing? If so, how and when? _____
Yes No U 18. Do you awaken with sore jaws? If so, how often? _____
Yes No U 19. Do you notice popping, clicking, grating or soreness in the joints just in front of your ears? If so, please describe: _____
Yes No U 20. Have you ever been treated for TMJ (temporomandibular joint) problems? If so, describe: _____
_____
Yes No U 21. Do you get headaches? If so, where and how often? _____
22. When was your last dental cleaning? _____
23. Date of last FULL MOUTH dental x-rays? _____
Yes No U 24. Have you ever had a frightening experience in the dental office?
Yes No U 25. Have you had previous gum trouble? If so, describe: _____
Yes No U 26. Have you had a previous gum abscess or gum boil? If so, when and what area? _____
27. If you have had previous gum treatment, who performed the treatment and what type of treatment was performed? _____
Yes No U 28. Would the loss of a tooth (teeth) disturb you?
Yes No U 29. Would wearing a partial denture or false teeth bother you? If so, how much? _____
Yes No U 30. Are any of your teeth loose? If so, which ones? _____
Yes No U 31. What concerns you the most about your mouth? _____
Yes No U 32. Do you suck mints, Lifesavers, etc. regularly? _____
Yes No U 33. Estimate the number of cups, glasses, etc., you consume each day on the average of:
coffee _____ tea _____ soft drinks _____ alcoholic beverages _____

**Do you have any dental problems or questions not covered in the above questions? If so, what? _____
_____
_____

Date _____

Patient's Signature _____
(Or that of parent or guardian if patient is under 18 years of age)

Guardian's Printed Name _____

Date first reviewed _____

Periodontist's Signature _____

Periodontist's Printed Name_____

Date_____ **Patient's Initial (or Parent/Guardian if under 18 years old) _____**