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EXCELLENCE IN PERIODONTICS

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PERSONAL INFORMATION

Date: _____

Name: _____ ***DOB:*** _____
LAST *FIRST* *MI*

Home Phone: _____ ***Work Phone:*** _____ ***Height:*** _____ ***Weight:*** _____

Name of Spouse: _____ ***Closest Living Relative:*** _____

If you are completing this form for another person, what is your relationship to that person? _____

MEDICAL INFORMATION

Are you in good health? _____ YES _____ NO

Has there been any change in your general health within the past year? _____ YES _____ NO

When was your last physical exam? _____

Are you presently under the care of a physician? _____YES _____NO
If so, what is the condition being treated? _____

Have you experienced a serious illness, operation or have been hospitalized in the past 5 years? _____YES _____ NO
If so, what was the illness or problem? _____

Are you taking any medications, including nonprescription medications? _____YES _____NO
If so, please list: _____

Are you allergic to any medications? _____ YES _____ NO
If so, please list: _____

DO YOU HAVE OR HAVE YOU HAD?

YES	NO		YES	NO	
_____	_____	*AIDS/HIV positive*	_____	_____	*Hepatitis (jaundice)*
_____	_____	*Allergies*	_____	_____	*High/Low blood pressure*
_____	_____	*Arthritis*	_____	_____	*Kidney disease*
_____	_____	*Asthma*	_____	_____	*Liver disease*
_____	_____	*Bleeding problems*			*Lung disease/Respiratory*
_____	_____	*Blood disease*	_____	_____	*problems, tuberculosis, etc.*
_____	_____	*Blood transfusion*	_____	_____	*Prosthetic joints/heart valve*
_____	_____	*Cancer or tumor*	_____	_____	*Psychological problems*
_____	_____	*Chest pains/Heart attack*	_____	_____	*Radiation of the head/neck*
_____	_____	*Contact lenses*	_____	_____	*Rheumatic Fever*
_____	_____	*Cortisone/Steroids*	_____	_____	*Shortness of breath*
_____	_____	*Diabetes*	_____	_____	*Stomach/Intestinal disease*
_____	_____	*Epilepsy (seizures)*	_____	_____	*Stroke*
_____	_____	*Fainting (frequent)*	_____	_____	*Swelling of hands or feet*
_____	_____	*Headaches (frequent)*	_____	_____	*Thyroid disease*
_____	_____	*Heart disease or murmur*	_____	_____	*Sexually transmitted disease*
_____	_____	*Do you smoke? If yes, how much?* _____			

WOMEN ONLY:

_____	_____	*Are you pregnant? What month?* _____
_____	_____	*Are you taking birth control pills?*
_____	_____	*Are you in or have you been through menopause?*

DENTAL INFORMATION

DO YOU:

YES	NO	
_____	_____	*Have any dental pain or discomfort now?*
_____	_____	*Fear the dentist or dental treatment?*
_____	_____	*Frequently clench or grind teeth when tire, tense, angry or asleep?*
_____	_____	*Have pain opening/closing your mouth?*
_____	_____	*Have gums which bleed when brushing or flossing?*
_____	_____	*Frequently wedge food between your teeth?*
_____	_____	*Have any other dental conditions that I should know about?*
_____	_____	*Brush your teeth regularly? How many times per day?* _____
_____	_____	*Floss your teeth regularly? How many times per day?* _____
_____	_____	*Use other hygiene aids? Dental floss, rubber tip, powder, water pik, electric toothbrush (Circle Which)*

ARE:

YES	NO	
_____	_____	*Your teeth sensitive to hot, cold or sweets?*
_____	_____	*You dissatisfied with the condition or appearance of your teeth?*
_____	_____	*You aware of any loose teeth?*

HAVE YOU:

YES	NO	
_____	_____	*Had problems with dental anesthesia (Novacaine)?*
_____	_____	*Had prolonged bleeding after tooth extraction/cleaning?*
_____	_____	*Noticed any shifting of your teeth recently?*
_____	_____	*Ever had orthodontic (braces) treatment?*
_____	_____	*Ever been told you had periodontal "gum" disease?*
_____	_____	*Ever had periodontal treatment?*
_____	_____	*Ever had any teeth extracted because of periodontal disease?*
_____	_____	*Ever had gum boils, abscesses or experienced a bad taste in your mouth?*
_____	_____	*Been seeing a dentist on a routine basis?*

_____/_____/_____ *Date of most recent dental cleaning*

Signature _____ ***DATE:*** _____

Patient or Parent/Guardian

CLARIFICATION OF POSITIVE ANSWERS (DOCTOR USE ONLY)

MEDICAL ALERT:

_____ YES _____ NO

Initial Vitals: BP: _____ PULSE: _____ RESP: _____ TEMPERATURE: _____