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Diplomate of the American Board of Periodontology

Practice Limited to Periodontics • Oral Medicine • Dental Implants

Date:____________________

Patient Name:____Name you prefer to be addressed as: ____________________

Date of Birth:______________Height:__________Weight:__________

Referred by:__________________________Dentist: ______________________Physician:______________________________

Blood Pressure:____________________Pulse:___________________________

HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions by circling either Yes or No. If you are uncertain about the question, leave it unanswered. All answers will be held in strict confidence.

1. Are you experiencing pain from your mouth at this time? — No Yes
2. Have you had your teeth cleaned in the last six months? — No Yes
3. How long have you been a patient of your current general dentist?________
4. Have you had previous gum treatment? — No Yes
5. Do your gums bleed when you brush your teeth? — No Yes
6. Do you think your teeth are moving or drifting? — No Yes
7. Have you noticed any mouth odors or bad tastes? — No Yes
8. Are your teeth sensitive to heat, cold or sweets? — No Yes
9. Do meats or other foods wedge between your teeth? — No Yes
10. Have you had your teeth straightened? — No Yes
11. Do your jaws feel tired at the end of the day? — No Yes
12. Do your jaws feel tired when you awaken in the morning? — No Yes
13. Do you grind or clench your teeth when you are nervous or while sleeping? — No Yes
14. Do your jaws crack or pop when you yawn or open your mouth? — No Yes
15. Would you be tremendously disturbed if you had to lose your teeth or wear dentures? — No Yes
16. Are you satisfied with the appearance of your teeth? — No Yes
17. Do you feel an attempt to save your teeth is a waste of time? — No Yes

GENERAL

18. Have you had any serious illnesses? — No Yes
19. Have you ever been hospitalized or had any operations? — No Yes
20. Have you ever been told that you need to be pre-medicated before dental appointments? — No Yes
    If yes, what medication was recommended?________________________
21. Have you ever had excessive or prolonged bleeding following a tooth extraction, cut or other injury?` — No Yes
22. Have you ever had an unusual or allergic reaction to any medications (Penicillin, Codeine, Aspirin)? — No Yes
23. Have you ever had a tumor or cancer? — No Yes
24. Did you ever receive x-ray, radium or cobalt treatments for some disease? — No Yes
25. Do you have any allergies? — No Yes
26. Do you have or suspect yourself of having AIDS? — No Yes
27. Have you recently lost a lot of weight without dieting? — No Yes
28. Do your have any blood disease such as anemia (thin blood)? — No Yes
29. Are you currently taking any medications or drugs (antibiotics, steroids, anticoagulants)? — No Yes
30. Approximately how long has it been since you were last seen by a physician?________________
    What was this appointment for?________________________
    When was your last complete physical?________________________
31. Are you currently under the care of a physician? — No Yes

HEAD AND NECK

Question		
32. Have you ever had severe pains of the face or head?	No	Yes
33. Have the glands (lymph nodes) in your neck ever become enlarged or swollen?	No	Yes
34. Do you have sinus trouble?	No	Yes
35. Do you have a sore or hoarse throat?	No	Yes

RESPIRATORY

Question		
36. Have you had tuberculosis (consumption)?	No	Yes
37. Do you have hay fever or asthma?	No	Yes
38. Do you have emphysema?	No	Yes
39. Have you ever smoked?	No	Yes
How long did you smoke for? How much? Approximate quit date:		
40. Do you currently smoke?	No	Yes
How much?		
41. Do you have a persistent cough or sometimes cough up blood?	No	Yes

CARDIOVASCULAR

Question		
42. Have you ever had rheumatic fever, growing pains or twitching of the limbs?	No	Yes
43. Have you ever had a heart attack?	No	Yes
44. Have you ever had a stroke (apoplexy, CVA)?	No	Yes
45. Have you ever been told that your blood pressure was too high or too low?	No	Yes
46. Do you have a heart murmur (leaky valve)?	No	Yes
47. Do you have hardening of the arteries (arteriosclerosis)?	No	Yes
48. Do you get pains in the heart or chest (angina pectoris)?	No	Yes
49. Do your ankles become swollen at times?	No	Yes
50. Does mild exercise leave you short of breath?	No	Yes
51. Do you get tired easily?	No	Yes

GASTROINTESTINAL

Question		
52. Have you had jaundice (yellow eyes or skin)?	No	Yes
53. Have you had liver disease (hepatitis)?	No	Yes
54. Do you drink alcohol regularly?	No	Yes
55. Do you have any trouble with your stomach (ulcer, gastritis)?	No	Yes

GENITOURINARY

Question		
56. Have you ever had any kidney disease (glomerulonephritis, pyelonephritis)?	No	Yes
57. Have you ever had syphilis or other venereal diseases?	No	Yes
58. Do you get up 2-3 times a night to urinate?	No	Yes
59 Are you thirsty much of the time?	No	Yes
60. Are you pregnant or suspect yourself of being pregnant at this time?	No	Yes

NERVOUS SYSTEM

Question		
61. Have you ever had a nervous breakdown?	No	Yes
62. Have you ever been treated for epilepsy?	No	Yes
63. Are you often dizzy or wobbly?	No	Yes
64. Are you a nervous or tense person?	No	Yes

ENDOCRINE

Question		
65. Have you ever had diabetes?	No	Yes
66. Does anyone in your family have diabetes?	No	Yes
67. Do you have thyroid disease?	No	Yes
68. Do you feel that you are in good health at the present time?	No	Yes

I have filled out this medical history honestly and to the best of my ability. I understand that I am responsible for any charges not covered by my insurance company (ies).

Patient/Parent Signature________________________ Date____________

Current Medication(s)________________________________

Chief Complaint: ________________________________