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Practice Limited to Periodontics, Implantology,
Regenerative and Cosmetic Periodontal Procedures

Patient's Name:_____

Medical History

Directions: *If the answer is YES, put a circle around YES. If the answer is NO, put a circle around NO. Answer only question you are certain about. PLEASE USE A PEN.*

1. Are you in good health? . . . . . YES NO
   a. Has there been any change in your general health within the past year? . . . . YES NO

2. My last physical was on
   _____

3. Are you now under the care of a Physician? . . . . . YES NO
   a. If yes, what is the condition(s) being treated? _____
   _____

4. The name, address and phone number of my Physician is: _____
   _____

5. Have you had any serious illness, operation, or been hospitalized? . . . . . YES NO
   a. If yes, what was the illness or operation?
   _____
   _____

6. Are you taking any of the following:
   a. Antibiotics or sulfa drugs . . . . . YES NO
   b. Anticoagulants (blood thinners). . YES NO
   c. Medicine for high blood pressure. YES NO
   d. Cortisone (corticosteroids) . . . . . YES NO
   e. Tranquilizers . . . . . YES NO
   f. Aspirin . . . . . .YES NO
   g. Insulin Glucophage (Orinase) or similar drug . . . . . YES NO
   h. Nitroglycerin . . . . . YES NO
   i. Antihistamine . . . . . YES NO
   j. Thyroid or other hormone drugs. . YES NO
   k. Zometa (Bisphosphonates) . . . . . YES NO
   l. Vitamins . . . . . YES NO
   m. List other medications: _____
   _____

7. Are you allergic or have you reacted adversely to:
   a. Local Anesthetics. . . . . YES NO
   b. Antibiotics – Please List . . . . . YES NO
   _____
   c. Sulfa Drugs . . . . . YES NO
   d. Barbituates, sedatives or sleeping pills . . . . . YES NO
   e. Aspirin . . . . . YES NO
   f. Codeine or other narcotics . . . . . YES NO
   g. Latex . . . . . YES NO
   h. List other Drugs or Medication:
   _____
   _____

8. Do you have or have you had any of the following diseases or problems:
   a. Rheumatic fever or rheumatic heart disease . . . . . YES NO
   b. Congenital heart lesions . . . . . YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . YES NO
   (1) Heart Murmurs . . . . . YES NO
   (2) Mitral Valve Prolapse . . . . . YES NO
   (3) Cardiac Stints . . . . . YES NO
   d. Allergies . . . . . YES NO
   e. Asthma, Hay Fever or Hives . . . YES NO
   f. Fainting Spells or Seizures . . . . . YES NO
   g. Diabetes, Type I or Type II . . . . YES NO
   h. History of diabetes in family. . . . YES NO
   i. Hepatitis, A B or C (circle) . . . . . YES NO
   j. Arthritis . . . . . YES NO
   k. Inflammatory Rheumatism (painful, swollen joints) . . . . . YES NO
   l. Stomach ulcers . . . . . YES NO
   m. Kidney trouble. . . . . YES NO
   n. Tuberculosis. . . . . YES NO
   o. Do you have a persistent cough or do you cough up blood? . . . . . YES NO
   p. Low Blood Pressure . . . . . YES NO
   q. Have you tested positive for HIV YES NO
   r. Artificial joints (hip, knee, etc.) . YES NO
   s. List any other Disease: _____
   _____

   Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . YES NO
   _____
   _____

9. Have you had abnormal bleeding associated with previous extractions or surgery? YES NO
   a. Do you bruise easily? . . . . . YES NO
   b. Have you ever required a blood transfusion? . . . . . YES NO
      If so, explain the circumstances and date:
      _____

10. Do you have any blood disorders? . . YES NO

11. Have you had surgery or x-ray treatment for a tumor, growth or other condition? YES NO
    a. If so, did it involve the head or neck region? . . . . . YES NO

12. Have you had any serious trouble associated with previous dental treatment? . . YES NO
    If so, please explain: _____
    _____

13. **Women:**
    a. Are you pregnant? . . . . . YES NO
    b. Have you reached menopause? YES NO

Other Important Information

1. Do you see a dentist regularly? . . . . YES NO
   Date of last dental visit: _____
   Dentist's Name: _____

2. Have you had previous periodontal treatments? . . . . . YES NO
   If YES, please describe: _____
   _____

3. Any special dental problems? _____
   _____

4. Have you had or do you have:

	Have Had	Have Now
a. Bleeding of your gums . . .	☐	☐
b. swelling of your gums. . . .	☐	☐
c. any dental pain.	☐	☐
d. bad breath	☐	☐
e. bad taste	☐	☐

5. Is there a sensitivity in your mouth to:
   ☐Heat ☐Cold ☐Sweets ☐Biting ☐Chewing

6. Do you smoke? . . . . . YES NO
   If YES, what do you smoke? _____
   How much? _____

7. Do you drink alcohol? . . . . . YES NO
   How often? _____

8. **TMJ, Headaches, Facial Muscle Pain**
   Have you had or do you have now:
   a. A great deal of stress . . . . . YES NO
   b. Grind your teeth at night . . . . . YES NO
   c. Clench your teeth during the day YES NO
   d. Popping sounds from your jaw joints YES NO
   e. Treatment for a TMJ disorder or pain YES NO
   f. Wear a night guard or splint for TMJ treatment . . . . . YES NO
   g. Pain in the jaw muscles or facial muscles . . . . . YES NO
   h. Headaches or Migraines . . . . . YES NO
   i. Orthodontic treatment, Braces, or Invisalign . . . . . YES NO

9. **Periodontal Aids**
   a. Are you an aggressive brusher . . YES NO
   b. What type of toothbrush do you use?
      ☐ Hand: _____
      ☐ Electric: _____
   c. How often do you brush? _____
   d. Do you use a gum massager (rubber tip)? YES NO
   e. Do you use mouth wash regularly? . .YES NO
   f. Do you use a water spray device? . . . YES NO
   g. Do you use dental floss? . . . . . YES NO
   h. toothpicks or other implements? YES NO
   i. Have you had oral hygiene instruction? . . . YES NO

10. **Snoring and Sleep Apnea**
    a. Do you snore? . . . . . YES NO
    b. Do you have sleep apnea? . . . . . YES NO
    c. Do you wake up tired? . . . . . YES NO
    d. Have you been evaluated or tested for sleep apnea? . . . . . YES NO
    e. Do you wear a snore guard or CPAP device? . . . . . YES NO

Thank you for your cooperation. This data will help us give you the best possible care.
If you have any questions, please ask us.

Date _____ Signature _____

Date _____ Doctor's Signature _____