

DENTAL HISTORY

Your family dentist _____ City _____ Phone _____

How long have you been his/her patient? _____ Date of last visit _____

Purpose of today's visit: _____

Is there a main area of concern in your mouth? If so, what? _____

Please check the appropriate box in answer to the following questions.

Yes No ?

- Do your gums or teeth hurt now?
- Do your gums bleed?
- Are you aware of a bad taste or odor in your mouth?
- Have you had gum boils or abscesses within the past three months?
- Have you had a toothache within the past three months?
- Are any of your teeth particularly sensitive to hot or cold?
- Do you have frequent blisters or canker sores on your lips or mouth?
- Have you ever had "trenchmouth" or "pyorrhea"?
- Does your jaw ever "get out of joint", or "click" or cause pain?
- Do you clench or grind your teeth?
- Have you ever had periodontal (gum) treatment (deep cleanings and/or surgery)?
If so, when? _____
- Have you ever been treated by a periodontist
If so, when? _____ Name of periodontist? _____
- Have you ever had orthodontic treatment?
If so, when? _____ Name of orthodontist? _____
- Have you had any teeth extracted within the last three years?
If so, when? _____ How many? _____
- How many servings of alcoholic beverages do you have in a week? _____
- Do you smoke? If so, how much per day? _____ How many years? _____
- Have you ever smoked? If so, how much per day? _____ When did you quit? _____
- Do you use recreational drugs? *(These could conflict with medications we may need to use during your treatment)*
- Have you ever taken "Phen-Fen"?

Are you usually apprehensive about dental treatment? _____

How often do you brush your teeth? _____ floss? _____

When were your teeth last "cleaned" by a dentist or dental hygienist? _____

How often do you have your teeth cleaned? Every 3 4 6 12 months. (Circle one.)

Please check any items below that you use often in mouth care:

- Toothbrush Electric toothbrush Circle Brand: Sonicare Braun/Oral B Other _____
- Dental floss Gum stimulators, toothpicks, stimulents
- Rubber tip Water Spray
- Other _____

(Continued)

HEALTH HISTORY

Your general health is an important factor, and may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

Physician _____ City _____ Phone _____

Approximate date of last physical examination? _____ Where? _____

Reason for last physical examination _____

Please check the appropriate box in answer to the following questions.

- | Yes | No | ? | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health?
If not, what is the nature of the illness? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you now being treated by a physician?
If so, what for? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any drugs or medications? (including oral contraceptives or aspirin products)
If so, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized?
If so, when and what for? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had excessive bleeding requiring special treatment?
If so, details? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have diabetes? If so, are you well-controlled? _____ Age diagnosed? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your family ever had diabetes? If so, who? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you HIV (AIDS) Antibody positive? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced continuous excessive thirst or frequent night-time urination? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you lost weight (with good appetite)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do injuries or cuts heal very slowly? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does your mouth frequently seem dry? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you consider yourself to be under mental or emotional stress? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | (For females) Are you pregnant? If so, how many months? _____ |

Do you have or have you ever had any of the following?

- | Yes | No | ? | | Yes | No | ? | |
|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, liver disease A B C D | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever, sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath on mild exertion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous breakdown, mental illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease (TB, asthma, emphysema) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, sore joints |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease, irreg. heartbeats, heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint surgery or hip replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack, pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tumor or cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles or feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood trouble, anemia or leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain, pressure or tightness in chest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain on mild exertion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Radiation or Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting, dizzy spells or stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney or liver disease | | | | |

(OVER)

