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Diplomate, American Board of Periodontology

NAME: _____ **DATE:** _____
 Street: _____ Employer: _____
 City: _____ State: _____ Occupation: _____
 Zip Code: _____ Dentist: _____
 Home Phone: _____ Referred By: _____
 Business Phone: _____ Physician: _____
 Birth Date: _____ Marital Status: _____
 Height: _____ Weight: _____ Spouse's Name: _____
 Social Security #: _____ - _____ - _____ Spouse's Occupation: _____

MEDICAL HISTORY

NOTE TO PATIENT: These questions are for your benefit. This information will assist us in your diagnosis and treatment.

Check any of the following which apply to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Child Births |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Joint Replacement Prosthesis | <input type="checkbox"/> Sexually Transmitted Disease | |
| <input type="checkbox"/> Thyroid Disorder | | |

- Have you had a recent complete physical examination? _____ When? _____
- Has there been any change in your general health in the last year? _____
 Explain: _____
- Have you been under a doctor's care, been hospitalized or seriously ill during the past two years? _____ Explain: _____
- Do you take any medications or drugs, including aspirin, vitamins, hormones, herbs, antacids, steroids or birth control pills, presently or within the last six months?
 List: _____

Drug

Dose & Frequency

_____	_____
_____	_____
_____	_____

- Are you allergic or have you experienced an unusual reaction to drugs? _____
 Please list: _____
- Have you experienced any other allergic reactions? _____ Please list: _____
- Have you ever experienced excessive bleeding that required special treatment? _____
 Explain: _____
- Do you premedicate or have you ever premedicated for a dental appointment? _____
 Explain: _____

9. Is there a history of diabetes in your immediate family? _____
10. Are you required to restrict your diet, work or activities in any way? _____
Explain: _____
11. Do you smoke cigarettes? Yes ___ No ___ Did you ever smoke? Yes ___ No ___
cigars? ___ pipe? ___ How many per day? ___ For how long? _____
12. Have you ever been treated for a growth or tumor in any part of your body? _____
Explain: _____
13. Are you under a great deal of stress on a daily basis, or has your daily stress
increased? _____
14. Do you have frequent headaches? _____ Migraines? _____
What area of the head? _____ Duration? _____
15. Do you have any disease, condition or problem that you feel we should know
about? ___ If so, please explain: _____

FOR WOMEN:

Are you pregnant? ___ Due date: ___ Is your menstrual cycle regular? _____
Have you reached menopause? _____
Are you having any menopause symptoms? ___ Please list: _____

DENTAL HEALTH HISTORY

Check any of the following which you may have had or experienced:

- | | | |
|---|--|---|
| <input type="checkbox"/> Injury to Face or Jaw | <input type="checkbox"/> Sensitivity to Hot | <input type="checkbox"/> Aches in Jaw Joint |
| <input type="checkbox"/> Slow Healing Mouth Sores | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Clicking/Popping in Jaw |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mouth Odor | <input type="checkbox"/> Jaw Locking - open or closed |
| <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Bad Taste in Mouth | <input type="checkbox"/> Change in Bite |
| <input type="checkbox"/> Swollen Gums | <input type="checkbox"/> Tired or Sore Muscles | <input type="checkbox"/> Loose Teeth |

Which of the following do you use on a daily basis?

- Toothbrush Dental Floss Stimulents Toothpicks End-Tuft Brush Fluoride Rinse
 Mouthwash (what type) _____ Proxabrush Other _____ Electric Brush

1. If you are currently experiencing pain in your mouth, where is it located? _____
 2. How did it come to your attention that you have a periodontal problem? _____
 3. Do you feel strongly about keeping your teeth for the rest of your life? _____
 4. Are you happy with the appearance of your teeth? _____
 5. Have you had orthodontic therapy (braces)? _____ Type: _____ When: _____
 6. Have you had previous periodontal (gum) treatment? ___ Type: _____ When: _____
 7. Have you had oral surgery? Type: _____ When: _____
 8. Have you had crown and/or bridgework? _____ When: _____
 9. Have you ever worn a bite guard, bite plane or night guard? _____ When: _____
 10. Have you noticed any change in the position of your teeth? _____ Explain: _____

 11. Do you have any difficulty in chewing? _____ Explain: _____
 12. Is it difficult to open your mouth wide? _____
 13. Are you worried about receiving dental treatment? _____
If so, what is your main concern? _____
- Present Dentist: _____ How long: _____
Last Dental Treatment: _____ For what: _____
Last Cleaning: _____ Last X-rays: _____
Pattern of Dental Care: ___ regular (every ___ months) ___ sporadic ___ infrequent

Signature: _____

Date: _____
