PERIO SOLUTIONS

Innovators in Implant, Periodontal and Prosthetic Dentistry

NAME: _____ DATE: _____

Birth Date: _____ SS# ___-___-___ Married __ Divorced __ Single __ Widowed __

Address: _____ City _____ Zip _____

Phone:(___)___-_____(h)(___)___-_____(w)(___)___-_____(c) Email: _____

Employer: _____ Occupation: _____

Dentist: _____ Phone: (_____)_____-_____

Physician: _____ Phone: (_____)_____-_____

Person to Contact in Case of Emergency: Relationship Phone

_____ _____ (_____) _____-_____

Whom May We Thank for Referring You:

_____

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:

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

1. Have you had a recent complete physical examination?_____ When? _____
2. Has there been any change in your general health in the last year? _____
   Explain: _____
3. Have you been under a doctor's care, been hospitalized or seriously ill during the past two years?____ Explain: _____
4. 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

5. Are you allergic or have you experienced an unusual reaction to drugs?_____
   Please list: _____
6. Have you experienced any other allergic reactions?___ Please list: _____
   _____
7. Have you ever experienced excessive bleeding that required special treatment? ____
   Explain: _____
8. 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:

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

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

__Toothbrush __Dental Floss __Stimudents __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:**

- _____