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PRACTICE LIMITED TO PERIODONTICS AND IMPLANTOLOGY

ADULT EXAMINATION and HEALTH HISTORY QUESTIONNAIRE

Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

NAME First, Middle I, Last______________________________ ___________ **ADDRESS**____
BEST DAYTIME # ________________________________ **D.O.B.** __________________________ **PLEASE CIRCLE: Male or Female**

For the following questions please circle yes or no whichever applies. Your answers are for our records only and will be confidential.

1. Are you in good health? ……………………………………………………………………………………………… ……………………Yes No
2. Date of last physical exam____________________ Are you being treated by a physician………………………… ……………………Yes No
3. Have you ever had excessive bleeding requiring special treatment? ……………………………………………………… ……………………Yes No
4. Have you had a blood transfusion in the last five (5) years? …………………………………………………………… ……………………Yes No
5. Have you had surgery in the last five (5) years? If yes, for what? ____
6. Have you had any of the following conditions? If yes, state when.

Rheumatic Fever …………………....	Yes	No	Heart Murmur…………………..……	Yes	No	Pacemaker ……..…	Yes	No
Heart Disease ……………………...	Yes	No	Kidney Disease ……………………..	Yes	No	Stroke …………….	Yes	No
High or Low Blood Pressure ………	Yes	No	Respiratory Disorder ………………….	Yes	No	Arthritis …………...	Yes	No
Stomach Trouble ………………….	Yes	No	Sexually Transmitted Disease ………..	Yes	No	Anemia …………...	Yes	No
Blood Disease …………………….	Yes	No	Asthma ………………………………	Yes	No	Diabetes..................	Yes	No
Tuberculosis ………………………	Yes	No	Thyroid Disorder …………………….	Yes	No	Cancer …………….	Yes	No
Allergies …………………………...	Yes	No	Hepatitis (Liver disorder) ………….	Yes	No	Epilepsy …………...	Yes	No

Others: ____ Yes No

7. Has anyone in your family had diabetes? Yes No If yes, who: ____ Yes No
8. Are you allergic to any of the following drugs

Local Anesthesia (novocaine)……….	Yes	No	Barbiturates, Sedatives……….……….	Yes	No	Aspirin …….………	Yes	No
Penicillin …………………………….	Yes	No	Codeine ……………………………….	Yes	No	Ibuprofen…………. ..	Yes	No
Tetracycline ……………………….. .	Yes	No	Sleeping Pills ………………………….	Yes	No	Any other drugs ……	Yes	No
Other Antibiotics …………………...	Yes	No	Latex Allegies ………………………….	Yes	No	______________________		

9. Please list any medications you are taking, the dosage, the reason and how long you have been taking them, or attach list. (prescription, over the counter or illegal drugs)____

10. Do you have a sensitivity to alcohol? ……………………………………………………………………………… ………………… Yes No
11. Have you ever had radiation treatment for a tumor or skin disease? ………………………………………………… ………………. .. Yes No
12. Have you ever been treated for any type of skin disease? ………………………………………………………………………………. Yes No
13. Are your joints ever painful or swollen? …………………………………………………………………………… …………………. Yes No
14. Do you get out of breath easily? ……………………………………………………………………………………………………….. Yes No
15. Do you smoke or have you ever smoked? If yes, how many packs per day? ……………………………………………………………. Yes No
16. If you are a former smoker, when did you quit? ………………………………………………………………………………………. Yes No
17. Have you ever had Periodontal treatment (treatment of the gums)……………………………………………………………………. Yes No
18. Have you ever had Orthodontic treatment (braces)? ………………………………………………………………… ………………… .Yes No
19. Have you ever had Endodontic treatment (root canal)? ……………………………………………………………… …………………. Yes No
20. Are you having pain in your mouth now? If yes, explain……………………………………………………………… …………………. Yes No
21. Do you have any artificial hip or joint replacement? ………………………………………………………………… …………………. Yes No
22. Have you ever been told you needed antibiotic prophylaxis for dental procedures? ……………………………………………………. Yes No
23. Are you being treated for Osteoporosis? Yes No Are you taking Fosamax or any other Osteoporosis medication. ……. Yes No
24. Have you ever taken prescription diet pills?.. Yes No
25. Do you have any disease, condition, or problem not listed above that I should know about? If yes,please explain……….….. Yes No

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**** 26.** Do you take a blood thinning medication daily? i.e.: coumadin/aspirin ……………………………………………………………. Yes No**

<u>Woman: Hormones do affect the oral tissue which makes the following questions important.</u>

27. Are you pregnant? ……………………………………………………………………………………………..…… ………………….….. Yes No
28. Have you reached menopause? ………………………………………………………………………………………… …………………….. Yes No
29. Do you take birth control pills or other oral contraceptives? ………………………………………………………… ………………….. Yes No
30. Do you take any prescribed hormonal supplements? ………………………………………………………………… ………………….. Yes No

I certify that I have read and understand the above health history.

Patients Signature__________________________ _____ ____**Date:** ___________________________
(parent or guardian if under 18)
Doctor's Signature ____ **Date:**__________________________