

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.

Table with 2 columns: Condition and Yes/No response. Rows include Rheumatic Fever, Heart Murmur, Pacemaker, Heart Disease, Kidney Disease, Stroke, High or Low Blood Pressure, Respiratory Disorder, Arthritis, Stomach Trouble, Sexually Transmitted Disease, Anemia, Blood Disease, Asthma, Diabetes, Tuberculosis, Thyroid Disorder, Cancer, Allergies, Hepatitis (Liver disorder), Epilepsy, and Others.

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 Allergies 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

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

Woman: Hormones do affect the oral tissue which makes the following questions important.

- 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: