Name .... Date of Birth .... Married ☐ Single ☐

Home Address .... City .... Zip ....

Occupation .... Employed by ....

Home Phone .... Business Phone .... Cell Phone ....

Name of Spouse .... Occupation ....

Spouse Employed by .... Business Phone ....

Dentist .... Phone ....

Physician .... Phone ....

Social Security # .... Referred by ....

The present health of the patient as well as past medical and dental history are of importance in the diagnosis and treatment of periodontal disease. Although many of these questions may seem unrelated to your present periodontal problem, they may provide important information for the management of your case. Answers to the following questions are for our records and will be considered confidential.

DENTAL AND MEDICAL HISTORY

NO YES

☐ ☐ Are you in good health?

☐ ☐ Did you have a physical exam within the last year?

☐ ☐ Are you now under the care of a physician?

☐ ☐ Have you had a serious illness, operation or been hospitalized for any reason?

☐ ☐ Are you HIV positive?

☐ ☐ Do you have, or have you had, any of the following diseases or problems:

- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Tumor or cancer
- ☐ Cardiovascular disease (heart trouble)
- ☐ Asthma or hay fever or sinusitis
- ☐ Allergy
- ☐ Fainting spells or seizures
- ☐ Diabetes
- ☐ Diabetes in family
- ☐ Hepatitis, jaundice or liver disease
- ☐ Arthritis
- ☐ Stomach ulcers
- ☐ Kidney trouble
- ☐ Tuberculosis
- ☐ Low or high blood pressure
- ☐ Thyroid trouble
- ☐ Glaucoma
- ☐ Psychiatric care
- ☐ Other mental health problem

☐ ☐ Have you had abnormal bleeding with previous extractions or surgery?

☐ ☐ Are you taking any of the following:

- ☐ Cortisone (steroids)
- ☐ Tranquilizers
- ☐ Aspirin
- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners)
- ☐ Medicine for high blood pressure

☐ ☐ Are you very nervous or under tension?

☐ ☐ Are you allergic or have you reacted adversely to:

- ☐ Codeine
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin
- ☐ Dental Injections
- ☐ Penicillin or other antibiotics
- ☐ Others

☐ ☐ Have you ever had "Trench Mouth" or Vincent's infection?

☐ ☐ Have you ever had orthodontic treatment?

☐ ☐ Have you ever worn any dental appliances?

☐ ☐ Do you smoke? if so, how much ....

☐ ☐ Have you ever found yourself grinding, clenching, or gritting your teeth?

Day .... Night ....

☐ ☐ Have you ever had periodontal treatment?

When was the first time you were seen by the referring dentist? ....

Please state briefly the reason you were referred to this office, and any additional comments you would like to make..

Have you any diseases, conditions, or illnesses not included above that would be considered pertinent? If so explain ....

WOMEN

☐ ☐ Are you pregnant?

☐ ☐ Do you have any problems associated with your menstrual period?

☐ ☐ Are you taking birth control pills?

☐ ☐ Have you undergone, or are you undergoing menopause?

Date .... Patient's Signature ....