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Periodontics and Dental Implants
Diplomate, American Board of Periodontology

Patient Name:______________________________
Last First MI

Birth Date:____________

MEDICAL AND DENTAL HISTORY

Please print and answer all questions and sign the last page. All information provided is confidential.

GENERAL HEALTH

Physician: ______________________________
Name
____
Address
____
Phone #

BP: **P:**

Have you ever had any of the following:

Yes	No		Yes	No		Yes	No	
o	o	Heart problem/murmur/attack	o	o	High blood pressure	o	o	Latex allergy
o	o	Shortness of breath	o	o	Low blood pressure	o	o	Artificial joints
o	o	Bleeding problem	o	o	Kidney problems	o	o	Chemical dependency
o	o	Liver problem	o	o	Rheumatic fever	o	o	Circulatory problems
o	o	Artificial heart valves	o	o	Tuberculosis	o	o	Fainting
o	o	Hepatitis A B C	o	o	AIDS/HIV	o	o	Cholesterol problems
o	o	Anemia	o	o	Swollen ankles	o	o	Pacemaker
o	o	Excessive thirst	o	o	Stomach ulcers	o	o	Thyroid problems
o	o	Frequent urination	o	o	Delayed wound healing	o	o	Psychiatric care
o	o	Diabetes Type I or II	o	o	Hemophilia	o	o	Back problems
o	o	Organ Transplant	o	o	Arthritis or rheumatism	o	o	Chemotherapy
o	o	Venereal disease	o	o	Epilepsy, seizures	o	o	Cortisone/steroid treatment
o	o	Cancer or radiation therapy	o	o	Osteoporosis	o	o	Headaches
o	o	Anticoagulants (blood thinners)	o	o	Glaucoma	o	o	Nervous problems
o	o	Asthma	o	o	Hay Fever	o	o	Skin rash
o	o	Prostate problems (males)	o	o	Respiratory disease	o	o	Mitral valve prolapse
o	o	Stroke	o	o	Emphysema	o	o	Herpes
o	o	Scarlet fever	o	o	Sinus problems	o	o	Smoking

Other: ______________________________

Please answer the following:

Yes	No	
o	o	1. Are you presently under the care of a physician? Reason____________
o	o	2. Have you been hospitalized in the last 10 years? Reason____________
o	o	3. Have you had any serious illnesses or operations? Describe____________
o	o	4. Do you faint easily?
o	o	5. Have you taken cortisone or steroids in the last 6 mos.? Reason____________
o	o	6. Are you or do you suspect that you may be pregnant? (Females)____________
o	o	7. Are you taking any birth control medication? If so, list____________
o	o	8. Are you taking hormone replacement therapy? If so, list____________
o	o	9. Have you ever had any reaction to anesthesia? If so, list____________
o	o	10. Have you ever taken Fen-Phen or Redux? If so, when? ____________
o	o	11. Do you have a family history of any diseases? Describe____________

Please list **ALL** medications that you are currently taking or have taken in the last 6 months. Please include vitamins.

Medication	Dosage	Reason	When started

Allergies:

- o Aspirin o Erythromycin o Codeine o Local anesthetic o Latex o Sulfa o Penicillin
- o Other ____

PHARMACY NAME:______________________________ PHONE:_____________________________________

DENTAL HISTORY

Reason for today's visit: ____
Date of last FULL MOUTH X-rays: ________________

Check if you have had any of the following:

o Bad breath	o Bleeding gums	o Clicking or popping of jaw	o Grinding teeth
o Loose teeth	o Sensitivity to hot or cold	o Dental Implants	o Sensitivity to sweets
o Mouth sores	o Pain when chewing	o Receding gums	o Clenching teeth
o Bite change	o TMJ problems	o Orthodontics (braces)	o Headaches

Please answer the following questions:

1. How would you describe your dental health? EXCELLENT GOOD FAIR POOR
2. What kind of toothbrush do you use? SOFT MEDIUM HARD ELECTRIC Type? ______________________
3. How often do you brush?_______________________
4. How often do you floss?________________________
5. Do you use any of the following? STIMUDENTS RUBBER TIP SUPERFLOSS PROXABRUSH
   OTHER___________________________________
6. What kind of toothpaste do you use?______________________________ Oral rinse? ____________________________
7. Estimate the number of cups, glasses, etc. you consume each day of:
   Coffee________ Tea_________ Soft drinks________ Alcoholic beverages__________
8. When was your last dental cleaning? ____

Yes	***No***	
o	o	9. Are you having trouble chewing satisfactorily?
o	o	10. Have you noticed spaces developing between your teeth?
o	o	11. Do you awaken with sore jaws?
o	o	12. Do you notice popping, clicking, grating or soreness in the joints just in front of your ears?
o	o	13. Have you ever been treated for TMJ (temporomandibular joint) problems? Describe____
o	o	14. Have you ever had a frightening experience in a dental office ? Describe ______________________________
o	o	15. Have you had previous gum trouble or treatment? Describe:______________________________
o	o	16. Have you had a previous gum abscess or gum boil? Describe: ______________________________
o	o	17. Would wearing a partial denture or false teeth bother you?

18. What concerns you most about your mouth?____
19. Have you **ever** smoked? YES NO How many packs per day?________ For how many years?_________
20. If you are a past smoker, when did you quit?____________

Signature of Patient or Legal Guardian ______________________________________ Date: ______________

Doctor Signature ____ Date: ______________
Tinou T. Roncone, DDS, MS