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 Practice Limited to Periodontics, Implantology,  
 Regenerative and Cosmetic Periodontal Procedures

**Patient's Name:** \_\_\_\_\_

**Medical History**

**Directions:** *If the answer is YES, put a circle around YES. If the answer is NO, put a circle around NO. Answer only question you are certain about. PLEASE USE A PEN.*

1. Are you in good health? . . . . . YES NO  
 a. Has there been any change in your general health within the past year? . . . . YES NO

2. My last physical was on \_\_\_\_\_  
 \_\_\_\_\_

3. Are you now under the care of a Physician? . . . . . YES NO  
 a. If yes, what is the condition(s) being treated? \_\_\_\_\_  
 \_\_\_\_\_

4. The name, address and phone number of my Physician is: \_\_\_\_\_  
 \_\_\_\_\_

5. Have you had any serious illness, operation, or been hospitalized? . . . . . YES NO  
 a. If yes, what was the illness or operation? \_\_\_\_\_  
 \_\_\_\_\_

6. Are you taking any of the following:  
 a. Antibiotics or sulfa drugs . . . . . YES NO  
 b. Anticoagulants (blood thinners). . YES NO  
 c. Medicine for high blood pressure. YES NO  
 d. Cortisone (corticosteroids) . . . . . YES NO  
 e. Tranquilizers . . . . . YES NO  
 f. Aspirin . . . . . YES NO  
 g. Insulin Glucophage (Orinase) or similar drug . . . . . YES NO  
 h. Nitroglycerin . . . . . YES NO  
 i. Antihistamine . . . . . YES NO  
 j. Thyroid or other hormone drugs. . YES NO  
 k. Zometa (Bisphosphonates) . . . . . YES NO  
 l. Vitamins . . . . . YES NO  
 m. List other medications: \_\_\_\_\_  
 \_\_\_\_\_

7. Are you allergic or have you reacted adversely to:  
 a. Local Anesthetics. . . . . YES NO  
 b. Antibiotics – Please List . . . . . YES NO  
 \_\_\_\_\_  
 c. Sulfa Drugs . . . . . YES NO

- d. Barbituates, sedatives or sleeping pills . . . . . YES NO  
 e. Aspirin . . . . . YES NO  
 f. Codeine or other narcotics . . . . . YES NO  
 g. Latex . . . . . YES NO  
 h. List other Drugs or Medication: \_\_\_\_\_  
 \_\_\_\_\_

8. Do you have or have you had any of the following diseases or problems:  
 a. Rheumatic fever or rheumatic heart disease . . . . . YES NO  
 b. Congenital heart lesions . . . . . YES NO  
 c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . YES NO  
 (1) Heart Murmurs . . . . . YES NO  
 (2) Mitral Valve Prolapse . . . . . YES NO  
 (3) Cardiac Stints . . . . . YES NO  
 d. Allergies . . . . . YES NO  
 e. Asthma, Hay Fever or Hives . . . YES NO  
 f. Fainting Spells or Seizures . . . . . YES NO  
 g. Diabetes, Type I or Type II . . . . . YES NO  
 h. History of diabetes in family. . . . YES NO  
 i. Hepatitis, A B or C (circle) . . . . . YES NO  
 j. Arthritis . . . . . YES NO  
 k. Inflammatory Rheumatism (painful, swollen joints) . . . . . YES NO  
 l. Stomach ulcers . . . . . YES NO  
 m. Kidney trouble. . . . . YES NO  
 n. Tuberculosis. . . . . YES NO  
 o. Do you have a persistent cough or do you cough up blood? . . . . . YES NO  
 p. Low Blood Pressure . . . . . YES NO  
 q. Have you tested positive for HIV YES NO  
 r. Artificial joints (hip, knee, etc.) . YES NO  
 s. List any other Disease: \_\_\_\_\_  
 \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . YES NO  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Have you had abnormal bleeding associated with previous extractions or surgery? YES NO  
 a. Do you bruise easily? . . . . . YES NO  
 b. Have you ever required a blood transfusion? . . . . . YES NO  
 If so, explain the circumstances and date:  
 \_\_\_\_\_

10. Do you have any blood disorders? . . YES NO

11. Have you had surgery or x-ray treatment for a tumor, growth or other condition? YES NO  
 a. If so, did it involve the head or neck region? . . . . . YES NO

12. Have you had any serious trouble associated with previous dental treatment? . . YES NO  
 If so, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**13. Women:**

- a. Are you pregnant? . . . . . YES NO  
 b. Have you reached menopause? YES NO

**Other Important Information**

1. Do you see a dentist regularly? . . . . YES NO  
 Date of last dental visit: \_\_\_\_\_  
 Dentist's Name: \_\_\_\_\_

2. Have you had previous periodontal treatments? . . . . . YES NO  
 If YES, please describe: \_\_\_\_\_  
 \_\_\_\_\_

3. Any special dental problems? \_\_\_\_\_  
 \_\_\_\_\_

4. Have you had or do you have: Have Had Have Now
- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| a. Bleeding of your gums . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| b. swelling of your gums. . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. any dental pain. . . . .        | <input type="checkbox"/> | <input type="checkbox"/> |
| d. bad breath . . . . .            | <input type="checkbox"/> | <input type="checkbox"/> |
| e. bad taste . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> |

5. Is there a sensitivity in your mouth to:  
Heat Cold Sweets Biting Chewing

6. Do you smoke? . . . . . YES NO  
 If YES, what do you smoke? \_\_\_\_\_  
 How much? \_\_\_\_\_

7. Do you drink alcohol? . . . . . YES NO  
 How often? \_\_\_\_\_

**8. TMJ, Headaches, Facial Muscle Pain**

- Have you had or do you have now:
- a. A great deal of stress . . . . . YES NO  
 b. Grind your teeth at night . . . . . YES NO  
 c. Clench your teeth during the day YES NO  
 d. Popping sounds from your jaw joints YES NO  
 e. Treatment for a TMJ disorder or pain YES NO  
 f. Wear a night guard or splint for TMJ treatment . . . . . YES NO  
 g. Pain in the jaw muscles or facial muscles . . . . . YES NO  
 h. Headaches or Migraines . . . . . YES NO  
 i. Orthodontic treatment, Braces, or Invisalign . . . . . YES NO

**9. Periodontal Aids**

- a. Are you an aggressive brusher . . YES NO  
 b. What type of toothbrush do you use?  
 Hand: \_\_\_\_\_  
 Electric: \_\_\_\_\_  
 c. How often do you brush? \_\_\_\_\_  
 d. Do you use a gum massager (rubber tip)? YES NO  
 e. Do you use mouth wash regularly? . . YES NO  
 f. Do you use a water spray device? . . . YES NO  
 g. Do you use dental floss? . . . . . YES NO  
 h. toothpicks or other implements? YES NO  
 i. Have you had oral hygiene instruction? . . . YES NO

**10. Snoring and Sleep Apnea**

- a. Do you snore? . . . . . YES NO  
 b. Do you have sleep apnea? . . . . . YES NO  
 c. Do you wake up tired? . . . . . YES NO  
 d. Have you been evaluated or tested for sleep apnea? . . . . . YES NO  
 e. Do you wear a snore guard or CPAP device? . . . . . YES NO

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Thank you for your cooperation. This data will help us give you the best possible care.  
 If you have any questions, please ask us.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_