



MEDICAL / DENTAL HISTORY FORM

Patient Name _____ Date of Birth _____

Do you have or have you had any of the following?

- Rheumatic fever or rheumatic heart disease NO YES
- Mitral valve prolapse or heart murmur NO YES
- Heart disease / heart attack NO YES
- Artificial heart valve NO YES
- Irregular heart beat NO YES
- Pacemaker NO YES
- High Blood Pressure NO YES
- Chest pains or angina NO YES
- Stroke NO YES
- Artificial joint NO YES
- Hepatitis / Liver disease NO YES
- Tuberculosis (TB) NO YES
- Thyroid trouble NO YES
- Kidney disease NO YES
- Diabetes NO YES
- Asthma NO YES
- HIV NO YES
- Arthritis NO YES
- Osteoporosis NO YES
- Radiation or Cancer chemotherapy NO YES

Do you have, or have you had any disease, condition or problem not listed here?
NO YES

When was the last time you were hospitalized?

Have you had excessive or prolonged bleeding requiring special treatment?
NO YES

Do you have any known allergies? NO YES
Please list each one.

Do you currently smoke tobacco? NO YES Have you ever smoked tobacco? NO YES
Do you smoke non-tobacco products? NO YES

How much do you smoke daily? _____

Do you use smokeless tobacco? NO YES How frequently do you use it? _____

Are you currently under the care of a physician(s)? YES NO

When were you last seen by a physician? _____

Name of physician _____

Street Address _____

Phone _____

Which **pharmacy** do you wish any prescriptions called in to?

Pharmacy Location (and phone number if possible).

Are you pregnant? _____ When is the estimated due date? _____

Are you nursing? _____

PERIODONTAL "GUM HEALTH" QUESTIONNAIRE

1) What is your chief concern, the reason for your visit to the periodontist? Please describe below.

2) Prior to your most recent visit, please estimate the last time you visited the dentist. _____

3) Prior to your most recent visit, please estimate the last time you had your teeth cleaned. _____

4) Do you know anyone in your family who has been diagnosed with periodontal disease? NO YES

5) Have you ever been treated for periodontal disease in the past? NO YES

(a) Do you remember what treatment you had? If so, please describe.

(b) How long ago did you receive this/these treatment(s)? _____

6) Have you ever had a dental implant placed? NO YES Do you have multiple implants? NO YES

7) If so, how long ago were your dental implants placed? _____

8) Have you ever had any problems with dental treatment in the past? If so please describe.

9) Do you have any other concerns you wish to speak about?

