HEALTH HISTORY

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identification. Even though these questions may seem unrelated to your periodontal condition, they can affect your overall diagnosis and treatment plan.

Please answer all questions. Check yes or no, whichever applies. All answers are confidential.

Medical History

	Yes	No
1. Are you in good health?	☐	☐
2. My last physical examination was on ____________________		
3. Are you now under the care of a physician?	☐	☐
If yes, what is the condition being treated?____________________		
4. Have you had any operations or serious illness?	☐	☐
5. Have you been hospitalized within the last five years?	☐	☐
If yes, what was the problem?____________________		
6. Are you taking any medicine, including recreational drugs (marijuana, cocaine, etc.)?	☐	☐
If so, what?____________________		
7. Have you ever been pre-medicated with antibiotics for your dental treatment?	☐	☐

8. Are you allergic to, or have you reacted adversely to any of the following:
☐ Penicillin; ☐ Erythromycin; ☐ Tetracycline; ☐ Aspirin; ☐ Codeine; ☐ Novocaine;
☐ Other; If other, what drugs?____________________

9. Do you have or have you ever had any of the following:

☐ Heart disease	☐ Heart attack	☐ Heart murmur	☐ A stroke	☐ High blood pressure
☐ Rheumatic fever	☐ Prosthetic heart valve	☐ Pacemaker	☐ Tumor or growth	☐ Radiation treatment
☐ Chemotherapy	☐ Arthritis; rheumatism	☐ Artificial joint	☐ Asthma	☐ Tuberculosis
☐ Emphysema	☐ Diabetes	☐ Anemia	☐ Venereal disease	☐ Hepatitis; jaundice
☐ Kidney disease	☐ Ulcers	☐ Diabetes	☐ Thyroid disease	☐ Herpes
☐ Epilepsy/seizures	☐ Nervous disorders	☐ AIDS or ARC	☐ Bleeding problems	☐ Blood transfusion
☐ Glaucoma	☐ Skin diseases			

	Yes	No
10. Has anyone in your family had diabetes?	☐	☐
11. Do you smoke? If yes, how much?__________per day	☐	☐
12. Do you have any disease, condition or problem not listed above that you think we should know about?	☐	☐
13. (Women) Are you pregnant? If so, how many months?__________	☐	☐
14. (Women) Do you have any problems associated with you menstrual period?	☐	☐
15. (Women) Do you take birth control pills?	☐	☐

Dental History

	Yes	No
1. Do you have pain from any area of your mouth?	☐	☐
2. Date of last dental cleaning____________________		

3. Do you have or do you use any of the following:

☐ Bleeding gums. When?__________	☐ Pain around ear	☐ Oral habits, e.g., nail biting, etc.
☐ Sensitive teeth	☐ Unusual sounds in ear while eating	☐ Toothbrush. Texture__________
☐ Loose teeth	☐ Bad breath	☐ Frequency of brushing________
☐ Food impaction	☐ Unpleasant taste	☐ Dental floss
☐ Clenching or grinding	☐ Periodontal treatment	☐ Interdental stimulators
☐ Burning of tongue	☐ Orthodontic treatment	☐ Water jet device
☐ Swelling or lumps in mouth	☐ Mouth breathing	☐ Disclosing tablets or solution
☐ Frequent blisters on lips or mouth		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will, without fail, inform Dr. Warner at my next appointment.

Date______________ **Signature**______________________________ **Reviewed by**____________________

Changes in health ____

Date______________ **Signature**______________________________ **Reviewed by**____________________

Changes in health ____