PERIODONTICS DENTAL & IMPLANTS, PC

WELCOME TO OUR PRACTICE
John R. Dodge, DMD, MS

Date ______________________
Patient Name ______________________
Your Dentist ______________________
Last Seen (mo/yr) ______________________
Your Physician ______________________
Last Seen (mo/yr) ______________________

Physician's Address ______________________
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Physician's Phone ______________________
Medical Alerts ______________________
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Medical / Dental History

☐ Yes ☐ No Are you taking any medications?
☐ Yes ☐ No Are you allergic to any medications?
☐ Yes ☐ No Have you been seriously ill in the last 5 years?
☐ Yes ☐ No Have you ever been hospitalized or had a serious illness?
☐ Yes ☐ No Do you need an antibiotic pre-medication for dental treatment?

WOMEN ONLY

☐ Yes ☐ No Are you pregnant? What month? __________
☐ Yes ☐ No Are you taking birth control?
☐ Yes ☐ No Are you in or have you been though menopause?
☐ Yes ☐ No Are you taking hormone pills?

DO YOU OR HAVE YOU EVER HAD?

☐ Yes ☐ No AIDS / HIV Positive
☐ Yes ☐ No Allergies
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis / Rheumatism
☐ Yes ☐ No Asthma / Hay Fever
☐ Yes ☐ No Bleeding Problems
☐ Yes ☐ No Blood Disease (Anemia)
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer or Tumor
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Chest Pains (Angina)
☐ Yes ☐ No Contact Lenses
☐ Yes ☐ No Cortisone / Steroids
☐ Yes ☐ No Diabetes (Sugar Disease)
☐ Yes ☐ No Drug Addiction
☐ Yes ☐ No Drug Reaction
☐ Yes ☐ No Epilepsy (Seizures)
☐ Yes ☐ No Fainting (Frequent)
☐ Yes ☐ No Headaches (Frequent)
☐ Yes ☐ No Head Injury
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Hepatitis (Jaundice)
☐ Yes ☐ No High / Low Blood Pressure
☐ Yes ☐ No Hives or Skin Rash
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Prosthetic Joint / Heart Valve
☐ Yes ☐ No Family history of Periodontal Disease
☐ Yes ☐ No Psychological Problems
☐ Yes ☐ No Radiation for Head / Neck Cancer
☐ Yes ☐ No Rheumatic Fever / Heart Disease
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Stomach / intestinal Disease (Ulcers)
☐ Yes ☐ No Stroke
☐ Yes ☐ No Swelling of Hands / Feet
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tuberculosis / Lung Disease
☐ Yes ☐ No Venereal Disease

Other: ______________________

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ARE YOU ALLERGIC OR HAVE REACTED ADVERSELY TO...

☐ Yes ☐ No Antibiotics (Penicillin, etc.)

☐ Yes ☐ No Aspirin

☐ Yes ☐ No Barbiturates (Sedatives or Sleeping Pills)

☐ Yes ☐ No Iodine

☐ Yes ☐ No Latex

☐ Yes ☐ No Local Anesthetics

☐ Yes ☐ No Narcotics (Codeine, etc.)

☐ Yes ☐ No Sulfa Drugs

Other ______________________________

☐ Yes ☐ No Are you taking any medications?

Please List

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DENTAL INFORMATION (DO YOU...)

☐ Yes ☐ No Have any dental pain or problems now?

☐ Yes ☐ No Fear the Dentist or dental treatment?

☐ Yes ☐ No Grind or frequently clench teeth?

☐ Yes ☐ No Have pain opening / closing your mouth?

☐ Yes ☐ No Have an unpleasant taste in your mouth?

☐ Yes ☐ No Have gums that bleed while brushing or flossing?

☐ Yes ☐ No Brush your teeth less than twice per day?

☐ Yes ☐ No Floss your teeth less than once per day?

☐ Yes ☐ No Use any tobacco products?

☐ Yes ☐ No Drink alcohol?

☐ Yes ☐ No Smoke?

ARE...

☐ Yes ☐ No Your teeth sensitive to hot, cold, or sweets?

☐ Yes ☐ No You dissatisfied with the condition or appearance of your teeth?

☐ Yes ☐ No You exposed to X-rays in your employment?

HAVE YOU...

☐ Yes ☐ No Had problems with dental anesthesia?

☐ Yes ☐ No Had prolonged bleeding after tooth extraction?

☐ Yes ☐ No Noticed any shifting of your teeth?

☐ Yes ☐ No Worn braces?

☐ Yes ☐ No Ever been told you have gum disease?

☐ Yes ☐ No Ever had periodontal (gum) surgery?

______________ Date of most recent cleaning

MEDICAL HISTORY UPDATE

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