IMPLANTS AND PERIODONTICS, LLC

Practice Limited to Periodontics and Implants

The following information is necessary to thoroughly evaluate your health. This information will be kept strictly confidential and will not be released to anyone. Thank you for taking the time to complete this questionnaire.

HEALTH HISTORY

Name:_____ Birth date:_____Date:_____

Circle the answer which applies:

1. Have you been under the care of a physician or hospitalized in the past year? Yes No
   Date of last examination_____
   Name and address of physician_____
2. Are you taking or have you recently taken *any* prescription, OTC or herbal medication? Yes No
   Please list:

3. Are you allergic to or have you reacted adversely to any of the following medications? Yes No
   Aspirin_____ Codeine_____ Penicillin_____ Local anesthetics_____ Latex _____Other medications_____

4. Do you have or have you had any of the following:

Heart Disease	Yes	No	Ulcers	Yes	No
Heart surgery	Yes	No	Diabetes	Yes	No
Congenital heart lesions	Yes	No	Family history of diabetes	Yes	No
Heart arrhythmia	Yes	No	Thyroid problems	Yes	No
Pacemaker/defibrillator	Yes	No	Arthritis or rheumatism	Yes	No
High Blood Pressure	Yes	No	Joint replacement	Yes	No
Stroke / TIA	Yes	No	Osteoporosis	Yes	No
Respiratory problems	Yes	No	Tumor or growths	Yes	No
Asthma	Yes	No	Radiation or chemotherapy	Yes	No
Persistent cough	Yes	No	Alcoholism or drug addiction	Yes	No
Hay fever or allergy	Yes	No	Nervousness	Yes	No
Sinus problems	Yes	No	Glaucoma	Yes	No
Epilepsy	Yes	No	Tobacco use	Yes	No
Fainting spells or seizures	Yes	No			
Persistent headaches	Yes	No	**Women Only:**		
Anemia	Yes	No	Are you pregnant	Yes	No
Abnormal Bleeding	Yes	No	Do you take contraceptives	Yes	No
Bruise easily	Yes	No	Have you reached menopause	Yes	No
AIDS or HIV infection	Yes	No	Do you take hormones	Yes	No
Hepatitis or jaundice	Yes	No			

DENTAL HISTORY

Why did you seek treatment at this time?_____

Do you see a dentist regularly? Yes No Dentist's Name_____

When were your teeth last cleaned? _____

Have you ever had periodontal or gum treatment before? Yes No When_____

Are you satisfied with the way your teeth look? Yes No Is it important for you to keep your own teeth? Yes No

Do you have or have you had?

a) Discomfort in the teeth, gums or jaw?	Yes	No	f) Tired jaw or facial muscles?	Yes	No
b) Bleeding gums?	Yes	No	g) Difficulty chewing?	Yes	No
c) Bad taste or bad breath?	Yes	No	h) Grinding or clenching of teeth?	Yes	No
d) Sensitivity to temperature or pressure?	Yes	No	i) Orthodontic treatment (braces)	Yes	No
e) Shifting of teeth within last 5 years?	Yes	No	j) Complications with dental treatment?	Yes	No

Which of the following do you use? Brush___Water Pik___Floss____Mouth Rinse ____Toothpicks___Other_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change I will inform the doctor at the next appointment.

CONSENT FOR TREATMENT

I hereby authorize the doctor or his designee to utilize various diagnostic aids, medications and therapy that are deemed necessary or advisable for diagnosis and treatment. I also understand that therapeutic procedures may involve certain risks.

_____ _____ _____

Signature of Patient, Parent or Guardian Dentist Signature Date