Advanced Periodontics and Dental Implants, LLC

Andrew R. Samuel, D.M.D.

Practice Limited to Periodontics
NJ Specialty Permit # 4005
1300 Highway 35 Plaza I

Office#: (732) 517-9800
FAX#: (732) 517-0319

WE WELCOME NEW PATIENTS!

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review this questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your permission.

PERSONAL INFORMATION

Today's date:_____

Name: **Mr. Mrs. Ms. Dr.** _____

Date of Birth:_____ Age:_____ Sex: M / F Height:_____ Weight:_____

Home address:_____

City: _____ State: _____ Zip_____

Home phone: _____ Cell phone: _____

Work phone: _____ Email address: _____

Best ways to contact you (circle all that apply): Call home Call work Call cell Text message Email

Emergency Contact Information Name: _____

Phone #: _____ Relationship to you: _____

Whom may we thank for referring you?: _____

Name of General Dentist: _____

HEALTH QUESTIONAIRE

Primary Care Physician:_____ Phone #:_____

YES NO Have you ever been told you need to premedicate with antibiotics prior to dental treatment?
If YES, for what reason/condition?_____
What antibiotic do you take?_____

YES NO Is your general health good?

YES NO Has there been a change in your health within the last year?

YES NO Have you been hospitalized or had a serious illness within the past three years?
What illness / reason for hospitalization?_____

YES NO Are you being treated by a physician now? Why?_____
When was your last medical examination? _____

HAVE YOU EXPERIENCED?

YES	NO	Chest pain (Angina)	YES	NO	Dizziness
YES	NO	Swollen ankles	YES	NO	Ringing in ears
YES	NO	Shortness of breath	YES	NO	Headaches
YES	NO	Recent weight loss,fever,night sweats	YES	NO	Fainting spells
YES	NO	Persistent cough, coughing up blood	YES	NO	Blurred vision
YES	NO	Bleeding problems, bruising easily	YES	NO	Seizures, epilepsy
YES	NO	Sinus problems	YES	NO	Excessive thirst
YES	NO	Difficulty swallowing	YES	NO	Frequent urination
YES	NO	Diarrhea, constipation, blood in stool	YES	NO	Dry mouth
YES	NO	Frequent vomiting, nausea	YES	NO	Jaundice
YES	NO	Difficulty urinating, blood in urine	YES	NO	Joint pain, stiffness

DO YOU HAVE OR HAVE YOU HAD?

YES	NO	Heart disease	YES	NO	HIV infection, AIDS, ARC
YES	NO	Heart attack, heart defect	YES	NO	Tumors, cancer
YES	NO	Heart murmur, mitral valve prolapse	YES	NO	Arthritis, Rheumatism
YES	NO	Rheumatic fever	YES	NO	Eye disease
YES	NO	Stroke, hardening of arteries	YES	NO	Skin disease, eczema
YES	NO	High blood pressure / hypertension	YES	NO	Anemia, blood disease
YES	NO	TB , emphysema, lung disease	YES	NO	VD (Syphillis,Gonorrhea,Chlamydia)
YES	NO	Hepatitis, liver disease	YES	NO	Herpes
YES	NO	Stomach, GI problems, ulcers	YES	NO	Kidney, bladder disease
YES	NO	Thyroid, adrenal disease	YES	NO	Diabetes
YES	NO	Family history of diabetes Who?_____			
YES	NO	Psychiatric care	YES	NO	Hospitalization
YES	NO	Radiation treatments	YES	NO	Blood transfusion
YES	NO	Chemotherapy	YES	NO	Surgery / Operations
YES	NO	Prosthetic heart valve	YES	NO	Pacemaker
YES	NO	Artificial joint / hip replacement	YES	NO	Contact Lenses

YES NO ***DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT?***

_____

DO YOU?

YES	NO	Smoke tobacco, cigarettes, cigars, pipe	How many packs per day?_____
YES	NO	Do you chew Tobacco	How much per day?_____
YES	NO	Drink alcohol	How much per day?_____
YES	NO	Use recreational drugs	What?_____

ARE YOU TAKING?

YES	NO	Aspirin
YES	NO	Anticoagulants (blood thinners)
YES	NO	Medicine for high blood pressure
YES	NO	Cortisone (steroids)
YES	NO	Digitalis or drugs for heart trouble
YES	NO	Insulin,Tolbutamide (Orinase) or similar drug

LIST YOUR MEDICATIONS

Do you take or have you been treated in the past with (circle): Fosamax Actonel Boniva Skelid Didronel

Have you had chemotherapy with (circle): Adredia Zometa

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY ?

YES	NO	Local anesthetics	YES	NO	Aspirin
YES	NO	Penicillin or other antibiotics	YES	NO	Iodine
YES	NO	Sulfa drugs	YES	NO	Codeine
YES	NO	Barbiturates, sedatives,sleeping pills	YES	NO	Latex Allergy

OTHER_____

_____

WOMEN

YES	NO	Are you pregnant?	YES	NO	Are you taking oral contraceptives?
YES	NO	Are you nursing?	YES	NO	Are you taking hormone therapy?

To the best of my knowledge, I have answered all questions accurately. I will inform my dentist of any changes in my health and / or medications.

Patient signature:_____ **Date:**_____