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 Swollen ankles
YES NO Shortness of breath
YES NO Recent weight loss,fever,night sweats
YES NO Persistent cough, coughing up blood
YES NO Bleeding problems, bruising easily
YES NO Sinus problems
YES NO Difficulty swallowing
YES NO Diarrhea, constipation, blood in stool
YES NO Frequent vomiting, nausea
YES NO Difficulty urinating, blood in urine

YES NO Dizziness
YES NO Ringing in ears
YES NO Headaches
YES NO Fainting spells
YES NO Blurred vision
YES NO Seizures, epilepsy
YES NO Excessive thirst
YES NO Frequent urination
YES NO Dry mouth
YES NO Jaundice
YES NO Joint pain, stiffness

DO YOU HAVE OR HAVE YOU HAD?

YES NO Heart disease
YES NO Heart attack, heart defect
YES NO Heart murmur, mitral valve prolapse
YES NO Rheumatic fever
YES NO Stroke, hardening of arteries
YES NO High blood pressure / hypertension
YES NO TB , emphysema, lung disease
YES NO Hepatitis, liver disease
YES NO Stomach, GI problems, ulcers
YES NO Thyroid, adrenal disease
YES NO HIV infection, AIDS, ARC
YES NO Tumors, cancer
YES NO Arthritis, Rheumatism
YES NO Eye disease
YES NO Skin disease, eczema
YES NO Anemia, blood disease
YES NO VD (Syphillis,Gonorrhea,Chlamydia)
YES NO Herpes
YES NO Kidney, bladder disease
YES NO Diabetes
YES NO Family history of diabetes Who?____
YES NO Psychiatric care
YES NO Radiation treatments
YES NO Chemotherapy
YES NO Prosthetic heart valve
YES NO Artificial joint / hip replacement
YES NO Hospitalization
YES NO Blood transfusion
YES NO Surgery / Operations
YES NO Pacemaker
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 with a biphosphonate drug i.e. (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 Penicillin or other antibiotics
YES NO Sulfa drugs
YES NO Barbiturates, sedatives,sleeping pills
YES NO Aspirin
YES NO Iodine
YES NO Codeine
YES NO Latex Allergy
OTHER____
____

WOMEN

YES NO Are you pregnant?
YES NO Are you nursing?
YES NO Are you taking oral contraceptives?
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:**______________

Doctor's signature:______________________________________ **Date:**______________