Advanced Periodontics and Dental Implants, LLC

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Practice Limited to Periodontics
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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 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

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	Blood transfusion
☐YES ☐NO	Rheumatic fever	☐YES ☐NO	Eye disease
☐YES ☐NO	Hospitalizations / Surgery / Operations	☐YES ☐NO	Skin disease, eczema
☐YES ☐NO	Arthritis, Rheumatism	☐YES ☐NO	Anemia, blood disease
☐YES ☐NO	Stroke, hardening of arteries	☐YES ☐NO	STI (syphilis, gonorrhea, chlamydia)
☐YES ☐NO	High blood pressure / hypertension	☐YES ☐NO	Herpes
☐YES ☐NO	TB , emphysema, lung disease	☐YES ☐NO	Kidney, bladder disease
☐YES ☐NO	Hepatitis, liver disease	☐YES ☐NO	Diabetes
☐YES ☐NO	Stomach, GI problems, ulcers		
☐YES ☐NO	Family history of diabetes Who?_____		
☐YES ☐NO	Thyroid, adrenal disease	☐YES ☐NO	Pacemaker
☐YES ☐NO	Psychiatric care	☐YES ☐NO	Tested positive for Covid-19
☐YES ☐NO	Radiation treatments	☐YES ☐NO	Family member or direct contact that tested positive for Covid-19
☐YES ☐NO	Chemotherapy		
☐YES ☐NO	Prosthetic heart valve	☐YES ☐NO	Positive Covid-19 antibody test
☐YES ☐NO	Artificial joint / knee / hip replacement		
☐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 bisphosphonate drug i.e. (circle): ☐Fosamax ☐Actonel ☐Boniva ☐Skelid ☐Prolia ☐Forteo ☐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:**_____

Doctor's signature:_____ **Date:**_____