

PERIODONTAL SPECIALISTS

World-class care and caring

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Name: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent's Name & Address (if under 18): _____

Home Phone: _____ Work/Cell: _____ Occupation: _____

Physician's Name: _____ Phone: _____

Referred by: _____ Phone: _____ Patient Since: _____

CONFIDENTIAL DENTAL HISTORY

YES NO

- Are you or have you recently been experiencing pain in your mouth or around your face?
- Do you have any dental conditions that you believe require immediate attention today?
- Are you worried about receiving dental treatment?
- Do you visit your dentist regularly? How often? _____
When did you last have your teeth cleaned? _____
- Have you ever had any teeth extracted? Why? _____
- Have you had any associated bleeding or healing problems? _____
- Have you ever had orthodontic treatment (teeth straightened)?
- Have you been diagnosed with periodontal disease or had gum problems? When? _____
- Have you ever had periodontal treatment? When? _____ By Whom? _____
- Do you have any removable bridges? For how many years? _____ Is it comfortable? _____
- Would you be disappointed if you had to lose all your natural teeth and wear false teeth?
- Did either of your parents lose all of their natural teeth?
- Are you dissatisfied with the appearance of your teeth? Why? _____
- Have you noticed any loose teeth? Which ones? _____
- Have any of your teeth separated, causing spaces between them?
- Do you have any difficulty chewing your food?
- Does food wedge between any of your teeth? Where? _____
- Are your teeth sensitive to cold, hot or sweets? Which? _____
- Do your gums ever bleed? When? _____
- Have you noticed any bad tastes or odors from your mouth?
- Have you ever had Vincent's infection or trench mouth? When? _____
- Do you brush your teeth daily? _____ times per day. If not, how often? _____
Do you use a hard, medium, or soft bristle brush? _____
- Do you use dental floss, a rubber tip or Stimudents daily? Which? _____
- Have you ever had oral hygiene instruction?
- Do you ever hear clicking or popping sounds from your jaw joint?
- Is it difficult to open your mouth as wide as you would like?
- Do you have any pain or soreness around your ears or other parts of your face?
- Are you aware of any clenching or grinding of your teeth?
- Do you have any habits, such as biting your nails, chewing on pipes, pencils, etc.?
- Have you ever been treated for problems with your jaw joint or for facial muscle spasms?
- Have you been under more than average nervous tension lately?
- Is your mouth dry in the morning when you awaken?
- Do you breathe through your mouth most of the time?

(Over Please)

CONFIDENTIAL MEDICAL HISTORY

YES NO

- Do you consider your general health to be good?
- Have you been examined by a physician within the last year?
- Is a physician treating you for any condition currently? What? _____
- Have there been any changes in your general health in the last year?
- Have you ever been seriously ill or had a major operation? What? _____
- Do you take Coumadin, aspirin or any blood thinners?
- Have you taken or currently taking an oral biphosphonate?
- Have you ever experienced a bad reaction to a dental anesthetic?
- Have you ever had an injury to your face or jaw?
- Have you ever had an injury or X-ray treatment for a tumor, growth or other condition near your mouth or lips?
- Have you ever had a blood transfusion?
- Have you been exposed to any communicable disease such as hepatitis or HIV?
- Have you recently gained or lost weight unintentionally?
- Are you ever short of breath or do you ever have chest pain on mild exertion?
- Do you bruise easily?
- Are you thirsty and/or hungry most of the time? Which? _____
- Is there any history of diabetes in your family?
- Do you have frequent canker or cold sores?
- Do you smoke or use chewing tobacco? Which and how much? _____
- For female patients, are you currently pregnant?
- Are you taking birth control pills?
- Have you undergone or are you undergoing menopause?
- Is there any other health information that you feel may influence your dental treatment?

Please list all current medications and/or herbal supplements: _____

Have you ever experienced an allergic reaction to any of the following?

- | YES | NO | | YES | NO | | YES | NO | |
|--------------------------|--------------------------|------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin | <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Bee Stings |
| <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Have you ever had any of the following?

- | YES | NO | | YES | NO | |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds or Bleeding Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder, such as Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (yellow skin and eyes) | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (sugar disorder) | <input type="checkbox"/> | <input type="checkbox"/> | Allergy (hives or skin rash) |
| <input type="checkbox"/> | <input type="checkbox"/> | High or Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Inflammatory Rheumatism |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Kidney & Bladder Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems, Attack or Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | X-ray Treatment or Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve or Stent |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Abuse | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems | | | |

Patient Signature

Date

Doctor Signature

Date