Connecticut Periodontal & Implant Associates

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DENTAL AND MEDICAL HISTORY FORM

Date: _____

Patient's Name _____ Spouse's Name _____

Street _____ City _____ State _____ Zip _____

Birth Date _____ Sex _____ Height _____ Weight _____

Phone: Home _____ Office _____ Cell _____

Reason for visit _____ Referred by _____

Dentist _____ Address _____ Phone _____

Physician _____ Address _____ Phone _____

Last physical exam _____ _____ _____

Employer _____ Occupation _____

Name of Patient's Dental Ins. Co. _____ Patient's Major Medical Ins. Co. _____

If covered, Spouse's Dental Ins. Co. _____ Person responsible for account _____

PLEASE CHECK ✔ YES, NO, OR DON'T KNOW AND UNDERLINE IF CONDITION, SYMPTOMS OR DRUGS ARE STATED.		**YES**	**NO**	**Don't Know**
1. Do you consider yourself to be in good health?	1.	____	____	____
2. Are you presently under a physician's care?	2.	____	____	____
3. Are you taking any medicine at the present time? *Please list on back*	3.	____	____	____
4. Have you ever had an operation?	4.	____	____	____
5. Have you ever been seriously ill?	5.	____	____	____
6. Have you ever been hospitalized?	6.	____	____	____
7. Have you ever received radiation treatments?	7.	____	____	____
8. Has your weight changed recently?	8.	____	____	____
9. Have you ever had Rheumatic heart disease, Rheumatic fever or Tuberculosis?	9.	____	____	____
10. Have you ever been told by a physician that you have heart trouble and if so when? _____	10.	____	____	____
11. Have you ever been told by a physician that your blood pressure is high or low?	11.	____	____	____
12. Are your joints often painful or swollen? Do you have arthritis?	12.	____	____	____
13. Have you ever been treated for anemia (thin blood)?	13.	____	____	____
14. Do you have or has anyone in your family had diabetes? Who? _____	14.	____	____	____
15. Have you ever had fainting spells or seizures?	15.	____	____	____
16. Have you ever had liver trouble, hepatitis or jaundice?	16.	____	____	____
17. Have you ever been treated for kidney or bladder trouble?	17.	____	____	____
18. Are you sensitive to or have you had any unusual reaction to **latex** or any medication such as **aspirin, penicillin, novocain, sulfa** or others?	18.	____	____	____
19. Do you have any other allergies and if so what? _____	19.	____	____	____
20. Do you have either hay fever or asthma?	20.	____	____	____
21. Have you ever been treated for stomach ulcers or stomach trouble?	21.	____	____	____
22. Are you on any special type of diet and if so why? _____	22.	____	____	____

(continued on back page)

	YES	NO	Don't Know
23. Are you having any dental pain? If so, how long have you noticed it?_____ ____ Can you describe it as sharp _____, dull _____, constant _____, intermittent _____, aggravated by hot_____, cold_____, pressure on chewing_____?	23. ____	____	_____
24. Do you frequently have canker sores, painful gums or a burning sensation in your mouth?	24. ____	____	_____
25. Do your gums ever bleed? If so, when? _____	25. ____	____	_____
26. When did you last have your teeth cleaned? _____ Where? _____			
27. How frequently have you had your teeth cleaned in the last 10 years? _____			
28. Do you have any teeth which seem to have become loose?	28. ____	____	_____
29. Have you noticed any bad breath or bad taste from your mouth?	29. ____	____	_____
30. Have you had periodontal treatment before? if so, when? _____ Where? _____	30. ____	____	_____
31. Have you ever had orthodontic treatment? If so, when? _____ Where? _____	31. ____	____	_____
32. Indicate approximately the date of your last extraction. _____			
33. Did you need any medication before or after the extraction?	33. ____	____	_____
34. Was there any problem with bleeding, pain or healing after the extraction?	34. ____	____	_____
35. Do you have any teeth which are sensitive to heat, cold or sweets?	35. ____	____	_____
36. Does your jaw ever click when you chew?	36. ____	____	_____
37. Do you ever have pain in your jaw or in the region in front of the ear?	37. ____	____	_____
38. Do you clench, grit or grind your teeth? If so, when? _____	38. ____	____	_____
39. Do you have any habits such as biting your nails, chewing on pencils or pipe?	39. ____	____	_____
40. Do you routinely use dental floss, rubber tip or stimudents? If so, which? (underline)	40. ____	____	_____
41. Do you smoke? What and how much? _____	41. ____	____	_____
42. Are you presently dissatisfied with the appearance of your teeth? Explain _____	42. ____	____	_____
43. Are you worried about undertaking periodontal treatment?	43. ____	____	_____

FOR FEMALES ONLY

44. How many pregnancies have you had? _____ How many children do you have? _____
45. If you are now pregnant state month _____ and name of obstetrician _____

PLEASE STATE ANY ADDITIONAL INFORMATION IN YOUR DENTAL OR MEDICAL HISTORY THAT YOU FEEL MAY BE HELPFUL IN DAIGNOSING AND TREATING YOUR CASE. _____

MEDICATIONS, HERBAL SUPPLEMENTS & VITAMINS: _____