Brock D. Herriges, DMD
Periodontics and Dental Implants

PATIENT INFORMATION & HEALTH HISTORY

PLEASE PRINT AND ANSWER ALL QUESTIONS:

NAME: _____ BIRTHDATE:_____ AGE: _____

Gender: _____ Marital Status:_____

Residence Address: _____ City: _____ Zip: _____

Phone: _____ Cell Phone: _____ Email: _____

Business Address: _____ City: _____ Zip: _____ Ph: _____

Occupation: _____ Employer: _____ Soc. Sec. No.: _____

Name of Spouse: _____ Birthdate: _____ Soc. Sec. No.: _____

Occupation: _____ Employer: _____

Business Address: _____ City: _____ Zip: _____ Ph: _____

Guarantor For Account (Name on Statement): _____

Nearest Relative or Friend Not Living With You: Name: _____ Phone: _____

Address: _____ City/ St/ Zip: _____

Your dentist/Referred by: _____ Phone _____ How long? _____

Previous dentist: _____ Phone _____ How long? _____

Your physician: _____ Phone: _____

Periodontal disease is caused by a combination of complex factors and the following questions are designed to help us identify them. The success of treatment is dependent upon this. Therefore, although some of the following questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health. Answers to these questions are for our records and will be considered confidential.

PLEASE DESCRIBE FULLY ANY YES ANSWERS.
USE THE BACK OF THE LAST PAGE IF NEEDED.

D.K. means don't know

		YES	NO	DK
1.	Do you presently have any dental pain or discomfort? _____	☐	☐	☐
	Please describe: _____ For how long? _____			
2.	Do your gums bleed? _____	☐	☐	☐
	Where? _____ When? _____			
3.	Are you conscious of bad taste or bad breath? _____	☐	☐	☐
4.	Do you have any pain or soreness in your gums? _____	☐	☐	☐
5.	Does food wedge between your teeth and cause gum irritation? _____	☐	☐	☐
6.	Do tartar and stain build up quickly? _____	☐	☐	☐
7.	Are your teeth painful to heat, cold, or sweets? (Circle which one(s)) _____	☐	☐	☐
8.	Are you conscious of loose teeth? _____	☐	☐	☐
9.	Have you noticed your teeth drifting, separating, or crowding? _____	☐	☐	☐
10.	Do you have problems chewing? _____	☐	☐	☐
11.	Have you noticed your bite changing? _____	☐	☐	☐
12.	Do you have any symptoms (pain, clicking, popping, etc.) in the jaw joints? _____	☐	☐	☐
13.	Do cavities develop quickly? _____	☐	☐	☐
14.	Date of last visit to dentist _____ What was done? _____			
15.	Last cleaning _____ Frequency of cleanings? _____			

D.K. means don't know

		YES	NO	DK
16.	How often have you visited the dentist in the past? _____			
17.	Do you feel anxiety when seeing a dentist? _____	☐	☐	☐
18.	Have you had difficulty following a dental extraction or other treatment (bleeding or infection)?	☐	☐	☐
	If yes, please explain. _____			
19.	Have you had previous periodontal treatment for gum disease? _____	☐	☐	☐
	Where, when, and by whom? _____			
	Is there a history of gum disease in your family? _____	☐	☐	☐
20.	Have you had previous orthodontic treatment (braces)? _____	☐	☐	☐
21.	Are you missing any teeth? _____	☐	☐	☐
	When lost? _____ Why? _____			
22.	Are there any missing teeth which have not been replaced? _____	☐	☐	☐
	Why not? _____			
	Your evaluation of replacements _____			
23.	Have you ever had surgery or radiation <u>treatment</u> for a tumor, growth, or other condition of your	☐	☐	☐
	head, mouth or neck? _____			
24.	Do you ordinarily place foreign objects between your teeth? (pens, pencils, pipe, fingernails, etc.)	☐	☐	☐
25.	Do you have a <u>habit</u> of biting your lip, tongue, or cheek? _____	☐	☐	☐
26.	Do you clench or grind your teeth during the day or night? _____	☐	☐	☐
27.	Are you conscious of any habit with your tongue (thrusting, etc.)? _____	☐	☐	☐
28.	How often do you brush your teeth? _____			
29.	Is your toothbrush: Manual: ☐ Medium or ☐ Soft? Electric: ☐ Oral B/ Braun or ☐ Sonicare?			
30.	How often do you use: Floss? _____ Toothpicks? _____			
	Mouth rinses?_____ Other? _____			
31.	Have you ever had instructions on how to clean your teeth? _____	☐	☐	☐
	By whom? _____			
32.	Are you <u>unhappy</u> with the way your teeth look? _____	☐	☐	☐
	Why? _____			
33.	How would you feel if you were to lose your teeth? _____			
	_____			
34.	What is your estimate of the health of your gums? _____			
	Good _____ Fair _____ Poor _____			

MEDICAL HEALTH HISTORY

1. How is your general health?_____

2. Date of last physical examination _____ Findings: _____

ANSWER YES or NO

3. Are you being treated by a physician or psychiatrist now? _____ ☐ ☐

4. Are you taking any medications or supplements? (prescription or over the counter) ☐ ☐

(Please list name of drug & dosage on back page.)

☐ antibiotics ☐ anticoagulants (blood thinner) ☐ herbal medication ☐ aspirin
☐ insulin ☐ blood pressure medicine ☐ cortisone (steroids) ☐ pain medicine
☐ hormones or contraceptives ☐ heart medicine ☐ Other _____

5. Have you ever had any serious illness or surgery that required hospitalization? _____ ☐ ☐

6. Are you on a special diet? _____ ☐ ☐

7. Do you have heart trouble? _____ ☐ ☐

☐ congestive heart failure ☐ chest pains on exertion/angina ☐ arrhythmia
☐ heart attack ☐ high or low blood pressure ☐ Other

8. Have you had a serious infectious disease? _____ ☐ ☐

☐ Hepatitis ☐ Tuberculosis ☐ Sexually Transmitted Disease ☐ AIDS/ HIV ☐ Other _____

9. Have you had any of the following? ☐ ☐

☐ liver disorder ☐ arthritis ☐ frequent headaches
☐ kidney disorder ☐ anemia ☐ fainting or dizziness
☐ lung problems ☐ glaucoma ☐ tension/stress
☐ cancer or tumor ☐ radiation treatment ☐ epilepsy
☐ diabetes ☐ periods of depression ☐ ulcer
☐ osteopenia/osteoporosis ☐ anxiety ☐ thyroid problems (goiter)

10. Have you had abnormal bleeding associated with extractions, surgery, injury or menstruation?_____ ☐ ☐

11. Have you ever had a blood transfusion?_____ ☐ ☐

12. Are you allergic to any drugs or have you experienced an unusual reaction to any drugs? _____ ☐ ☐

☐ dental anesthetic ☐ penicillin ☐ sedatives
☐ codeine/opioids ☐ sulfa drugs ☐ latex (rubber gloves)
☐ aspirin ☐ other antibiotics ☐ Other_____

13. Do you have any allergic condition? ☐ ☐

☐ asthma ☐ skin rashes ☐ Other_____
☐ hay fever ☐ sinus problems

14. Do you smoke?_____ Packs per day?_____ No. of years?_____ Do you use chewing tobacco?_____

Do you drink coffee daily?_____ How much? _____

15. Do you drink alcoholic beverages daily?_____ How much? _____

16. Do you use cocaine, marijuana, or other mind altering drugs? _____ ☐ ☐

17. Is there any tendency towards any illness in your family?_____ ☐ ☐

☐ diabetes ☐ cancer ☐ alcoholism ☐ heart disease ☐ Other_____

18. Do you have any disease condition or problem not listed above that I should know about? _____ ☐ ☐

_____

19. Women: Is there a possibility you are pregnant, or are you nursing a child? _____ ☐ ☐

_____ _____

(Signature of patient, parent or guardian) **(Date)**

(PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY.)

(over)

Drug Name	Dosage	Reason For Taking Medication