NAME_______________________________________________________________________________

Last First DOB Date

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identification. The following questions are important to the treatment of your periodontal conditions. Please answer all questions by circling YES or NO. All information will be kept confidential.

Do you or have you ever had:

**Cardiovascular System**

YES NO Heart attack and/or heart bypass surgery
YES NO Stroke
YES NO Pain or pressure in chest
YES NO Rheumatic fever or heart murmur
YES NO Swollen ankles or eyelids
YES NO High blood pressure
YES NO Low blood pressure
YES NO Frequent nose bleeds

**Respiratory System**

YES NO Shortness of breath
YES NO Respiratory disease or COPD (chronic obstructive pulmonary disease)
YES NO Asthma or chronic bronchitis
YES NO Hayfever or allergies
YES NO Tuberculosis, pneumonia or emphysema
YES NO Chronic cough, hoarseness or sore throat
YES NO Halitosis

**Gastrointestinal/Urinary**

YES NO Ulcers, stomach or intestinal problems
YES NO Frequent indigestion, diarrhea or vomiting
YES NO Appetite problem or difficulty in swallowing
YES NO Jaundice or hepatitis
YES NO Liver or gall bladder problems
YES NO Bladder infection
YES NO Kidney disease or frequent urination

**Nervous System**

YES NO Epilepsy
YES NO Nervous or mental disorders
YES NO Neuritis, neuralgia or numbness

**Bones or Joints**

YES NO Swollen or painful joints
YES NO Arthritis or rheumatism
YES NO Fractures or dislocations
YES NO Any condition requiring cortisone therapy
YES NO Any joint replacement

**Endocrine System**

YES NO Goiter or thyroid condition
YES NO Diabetes, if yes: average blood sugar (mg/dL) and/or HbA1c (%) ________________________
YES NO Family member with diabetes
YES NO Dry or burning mouth

**Women**

YES NO Currently pregnant
YES NO Nursing
YES NO Any chance you could be pregnant
YES NO Hysterectomy or ovariectomy
YES NO Menopause
YES NO Currently taking birth control pills

**(OVER)**

**Medication/Drugs**

YES NO Need for antibiotic premed prior to dental visits
YES NO Allergic to medication. If yes, which medication? ________________
YES NO Ever taken Fosamax, Actonel, Boniva, or other bisphosphonates or bone sparing drugs
YES NO Tobacco use. If yes, how much and how long? ________________
YES NO Alcohol use. If yes, how many drinks per week? ________________
YES NO Take St. John's Wort
YES NO Recreational drugs/controlled substances

**Dental History**

YES NO Reactions to local anesthesia
YES NO Difficulty getting numb
YES NO Reactions to latex

**Other**

YES NO Dizziness or fainting spells
YES NO Excessive bleeding following a scratch or tooth extraction
YES NO Blood transfusion
YES NO Positive test to HIV (AIDS virus)
YES NO Suspected contact with HIV
YES NO Bruise easily
YES NO Take blood thinners
YES NO Ear, eye, nose or throat trouble
YES NO Sinusitis or frequent headaches
YES NO Facial injury
YES NO Growths, tumors, cysts or cancers
YES NO Radiation or chemotherapy
YES NO Recent weight gain or loss
YES NO Major operation or hospitalization. If yes, please explain ________________
YES NO Skin rash, hives or other skin problems
YES NO Glaucoma. If yes, what type ________________
YES NO Do you consume grapefruit juice? (possible interaction with medications prescribed at the dental office)
**YES NO Any condition, not mentioned, we should know about?** ________________

Family Physician________________ Specialty________________ Date of last visit____________
Address ________________Phone number________________
Other Physician ________________ Specialty________________ Date of last visit____________
IF KAISER, MEDICAL RECORD NUMBER________________

**PLEASE LIST ALL MEDICATIONS, INCLUDING ANY OVER THE COUNTER MEDICATIONS, VITAMINS, & NUTRITIONAL SUPPLEMENTS**

| Name | Dose | Frequency | Purpose | Since |
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To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. I grant permission for my physician to be contacted for details and advice

Signature of patient, parent or guardian________________ Date____________

**FOR OFFICE USE:**

Baseline BP________ Pulse________ $0_2$ Sat________ REVIEWED BY: ________