PLEASE PRINT AND ANSWER ALL QUESTIONS, INITIAL BOTTOM OF EACH PAGE AND SIGN THE LAST PAGE. ALL INFORMATION PROVIDED IS CONFIDENTIAL.

Name (Dr/Mr/Mrs/Ms)________________________________Age____Birthdate________Height _____Weight_____
(Please Circle) Single Married Separated Divorced Widowed Partner
Residence Address________________________________ City_____________Zip__________Phone________________
Business Address_________________________________ City_____________Zip__________Phone________________
Home Fax ______________________ Office Fax ______________________ Cell Phone ______________________
Occupation _________________________Position ___________________Employer ____________________________
Name of Spouse ____
Occupation _________________________Position ___________________Employer ____________________________
Party Responsible for Payment ___________________________________Relation to You _______________________
Emergency Contact Other Than Spouse _______________________________________ Phone ____________________
Referred By ___________________________________City ______________________ Phone ____________________
Current Dentist _______________________________City ____________ How Long? ________ Frequency? ________
Previous Dentist _______________________________City ____________ How Long? ________ Frequency? ________
Your Physician ____How Long? _________________________
Physician's Address ___________________________City _______________________Phone _____________________
Date of Last Complete Physical Examination ______________________Purpose of Exam _________________________
Findings ____

GENERAL HEALTH: (Please circle 'Yes' or 'No'; If in doubt circle 'U', and fill in other information asked for)

YES NO U 1. Are you presently under the care of a physician? If so, why? ________________________________
YES NO U 2. Do you have any type of health problem? If so, what? ____________________________________
YES NO U 3. Do you have any type of heart problem? If so , what? ____________________________________
YES NO U 4. Do you have high or low blood pressure? If so, which? ____________________________________
YES NO U 5. Do you have shortness of breath after climbing one flight of stairs?
YES NO U 6. Do you bleed for more than 30 minutes after a minor cut or have any other minor bleeding problems? If so, what? ____
YES NO U 7. Are you taking any medications or drugs including aspirin, vitamins, recreation drugs? List each drug, reason and who prescribed the drug. (Use back of page if more space is needed)____
YES NO U 8. Have you ever taken medication for osteoperosis/osteopenia? If so, what?____________________
YES NO U 9. Have you been hospitalized in the last 10 years? If so, for what? __________________________
YES NO U 10. Do you faint easily?
YES NO U 11. Have you taken cortisone or steroids in the last 6 months? ___________________________________
YES NO U 12. Have you been under the care of a physician in the last 2 years other than for a routine physical? If so, for what? ____
YES NO U 13. Have you had any major illness or serious operation in the last 10 years? If so, please describe: ____
YES NO U 14. Do you have any kidney or liver problems? If so, describe:_________________________________
YES NO U 15. Have you had rheumatic fever? If so, when was it first diagnosed? __________________________
YES NO U 16. Do you have any type of artificial valve, joint pin, prosthetic hip, etc, in place now?
YES NO U 17. Do you have a heart murmur, mitral valve prolapse or heart click? (Please circle)
YES NO U 18. Have you ever received psychiatric care or psychotherapy? If so, which? (Please circle)
YES NO U 19. Have you ever tested positive for Tuberculosis?
YES NO U 20. Do you now or have you ever had Hepatitis? If so, when? __________________________________
YES NO U 21. Do you have AIDS or AIDS-Related Complex (ARC) or ever tested positive for the AIDS virus?

(Please circle each of the following medications to which you are allergic):

Acetaminophen	Aspirin	Carbocaine	Codeine	Demerol	Doxycycline	Duranest
Erythromycin	Halcion	Iodine	Keflex/Keflin	Latex	Morphine	Novacaine
Penicillin	Percodan	Phenaphen	Phenergan	Sulfa	Stadol	Tetracycline
Tylenol	Valium	Versed	Xylocaine			

List All Others: ____

Date____________________ Patients Initial (or Parent/Guardian if under 18 years old) _________________

MEDICAL HISTORY: DO YOU NOW OR HAVE YOU EVER HAD:

YES NO U 1. Anemia?
YES NO U 2. Frequently swollen ankles?
YES NO U 3. Stomach ulcers, diverticulitis, or ulcerative colitis?
YES NO U 4. Excessive thirst or hunger over extended period of time?
YES NO U 5. The need to get up nightly to urinate?
YES NO U 6. Cuts that tend to heal slowly?
YES NO U 7. Diabetes? If so, how is it treated? ________________
YES NO U 8. Hemophilia?
YES NO U 9. Implant or transplant? If so, describe. ________________
YES NO U 10. Thyroid disturbance or taken thyroid tablets?
YES NO U 11. Tuberculosis or emphysema?
YES NO U 12. Kidney or bladder disease?
YES NO U 13. Arthritis or rheumatism?
YES NO U 14. Venereal disease (syphilis, gonorrhea; herpes II)?
YES NO U 15. Epilepsy, convulsions or seizures?
YES NO U 16. Cancer or radiation therapy?
YES NO U 17. Do you smoke or use tobacco in any form? If so, frequency? ________________
YES NO U 18. Did you know that if you smoke, you have more problems with gum diseases and their treatment and have a higher risk of losing dental implants?
YES NO U 19. Do you wear contact lenses?
YES NO U 20. Are you taking any sort of tranquilizers?
YES NO U 21. Are you taking anticoagulants (blood thinners)?
YES NO U 22. Are you taking antacids regularly? If so, what? ________________
YES NO U 23. Are you taking mood elevators?
YES NO U 24. Do you have glaucoma?
YES NO U 25. Do you have asthma, hay fever or eczema?
YES NO U 26. Do you have liver problems?
YES NO U 27. Do you have prostate problems (males only)?

MEDICAL HISTORY (FEMALES ONLY)

YES NO U 28. Are you pregnant?
YES NO U 29. Have you had a hysterectomy or ovariectomy?
YES NO U 30. Are you taking birth control pills?
YES NO U 31. Have you been through menopause?
YES NO U 32. Have you had a miscarriage?

FAMILY HISTORY

YES NO U 1. Have any of your blood relatives had heart disease or high blood pressure?
YES NO U 2. Have any of your blood relatives had diabetes?
YES NO U 3. Have any of your blood relatives lost teeth as a result of gum disease? If so, who? ________________
YES NO U 4. Have we treated any of your relatives? If so, who? ________________

**Do you have any disease, medical condition or health problem not listed above that you think we should know about or that you believe might affect treatment in any way? ________________

____

____

**Do you have any questions before the examination? If so, what (use back of page if needed)? ________________

____

____

____

Date________________ **Patients Initial (or Parent/Guardian if under 18 years old)** ________________

DENTAL HISTORY

			1.	How would you describe your dental health? **EXCELLENT GOOD FAIR POOR**
			2.	What do you do to clean your teeth at home? Brush _______ How Often? _______ Floss _______ How Often? ________ Other (Bridge Cleaners, Stimudents, Rubber Tip, etc.) ________________ List and describe frequency. ____
			3.	Type of toothbrush used: **HARD MEDIUM SOFT MANUAL MECHANICAL**
YES	NO	U	4.	Have you had personal instruction in oral hygiene? By whom and when? ____________________
YES	NO	U	5.	Do you feel your present oral hygiene is effective in cleaning your mouth?
YES	NO	U	6.	Have you ever had orthodontic treatment (braces)?
YES	NO	U	7.	Are you satisfied with the way your teeth and gums look?
			8.	If unsatisfied, what would you wish to change? ________________________________
YES	NO	U	9.	Can you chew satisfactorily?
YES	NO	U	10.	Have you noticed spaces developing between your teeth? When did this begin? _______________
YES	NO	U	11.	Are your gums receding? If so, where? ________________________________
YES	NO	U	12.	Are your teeth sensitive to hot? If so, which ones? ______________________
YES	NO	U	13.	Are your teeth sensitive to cold? If so, which ones? _____________________
YES	NO	U	14.	Are you aware that sensitivity of the teeth to cold can be caused by grinding?
YES	NO	U	15.	Do you clench your teeth? If so, when? ________________________________
YES	NO	U	16.	Do you grind your teeth? If so, when? ________________________________
YES	NO	U	17.	Have you noticed your bite changing? If so, how and when? _________________
YES	NO	U	18.	Do you awaken with sore jaws? If so, how often? _______________________
YES	NO	U	19.	Do you notice popping, clicking, grating or soreness in the joints just in front of your ears? If so, please describe. ________________________________
YES	NO	U	20.	Have you ever been treated for TMJ (temporomandibular joint) problems? If so, describe: ________________________________
YES	NO	U	21.	Do you get headaches? If so, where and how often? _____________________
			22.	When was your last dental cleaning? ________________________________
			23.	Date of last FULL MOUTH dental xrays? ______________________________
YES	NO	U	24.	Have you ever had a frightening experience in the dental office?
YES	NO	U	25.	Have you had previous gum trouble? If so, describe: ____________________
YES	NO	U	26.	Have you had a previous gum abscess or gum boil? If so, when and what area? ______________
YES	NO	U	27.	If you have had previous gum treatment, who performed the treatment and what type of treatment was performed? ________________________________
YES	NO	U	28.	Would the loss of a tooth (teeth) disturb you?
YES	NO	U	29.	Would wearing a partial denture or false teeth bother you? If so, how much? ________________
YES	NO	U	30.	Are any of your teeth loose? If so, which ones? _______________________
			31.	What concerns you the most about your mouth? _______________________
YES	NO	U	32.	Do you suck mints, Lifesavers, etc. regularly? _______________________
			33.	Estimate the number of cups, glasses, etc., you consume each day on the average of: coffee _________ tea _________ soft drinks __________ alcoholic beverages __________

**Do you have any dental problems or questions not covered in the above questions? If so, what? ____________________
____
____

Date ___________________ Patient's Signature ________________________________
(Or that of parent or guardian if patient is under 18 years of age)
Guardian's Printed Name ________________________________

Date first reviewed ___________________ Periodontist's Signature ________________________________
Thomas G. Wilson, Jr., DDS

Revised February 2011