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Periodontics with Services in Dental Implants
Diplomates, American Board of Periodontology

Medical/Dental Questionnaire

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be confidential.

Patient Name ______________________________ Age__________

Name of Primary Care Physician ______________________ Date of last physical examination__________

PATIENT

	YES	NO
1. Are you now under the regular care of a physician? If so, what for?______________	q	q
2. Are you taking any medication(s) including non-prescription medicine? List Medications	q	q

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________

	YES	NO
3. Have you ever been advised to take medication prior to dental visits? If so, what?______________	q	q
4. Have you ever been hospitalized for any surgical operation or serious illness? What for? ______________	q	q
5. Do you use tobacco (smoking or chewing)?	q	q

6. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO	
q	q	Local anesthetics (eg. novocaine)	q	q	Latex Gloves
			q	q	Codeine / Pain Med
q	q	Penicillin or other antibiotics	q	q	Aspirin
			q	q	Metals:
q	q	Sulfa Drugs	q	q	Other:

7. WOMEN ONLY:	YES	NO
a) Are you pregnant or think you may be pregnant?	q	q
b) Are you nursing?	q	q

Do you have, or have you had, any of the following?

YES	NO		YES	NO		YES	NO	
❒	❒	Tuberculosis	❒	❒	High Blood Pressure	❒	❒	Arthritis / Rheumatism
❒	❒	Rheumatic fever	❒	❒	Low Blood Pressure	❒	❒	Depression / Psychiatric Care
❒	❒	Heart murmur	❒	❒	Heart Attack (when?______)	❒	❒	Irregular Heart Beat
❒	❒	Cardiac Pacemaker	❒	❒	Stroke	❒	❒	Jaundice
❒	❒	Heart Surgery	❒	❒	Surgical Pins or Plates	❒	❒	Stomach Ulcers
❒	❒	Heart Disease	❒	❒	Liver Disease	❒	❒	Respiratory Problems
❒	❒	Congenital Heart Disease	❒	❒	Kidney Disease	❒	❒	Sinus Trouble
❒	❒	Prosthetic Heart Valve	❒	❒	Leukemia	❒	❒	Allergies / Hayfever
❒	❒	Mitral Valve Prolapse	❒	❒	Anemia	❒	❒	Thyroid Condition
❒	❒	Artificial Joints	❒	❒	Epilepsy / Convulsions	❒	❒	Bleeding Problems
❒	❒	Diabetes	❒	❒	Fainting / Seizures	❒	❒	Recent Weight Loss
❒	❒	AIDS, ARC, HIV Infection	❒	❒	Glaucoma	❒	❒	Drug/ Alcohol Addiction
❒	❒	Cancer	❒	❒	Emphysema	❒	❒	ADD
❒	❒	Chemo / Radiation Therapy	❒	❒	Hearing Loss			
❒	❒	Hepatitis (type ?)	❒	❒	Asthma			

Yes	No	
		Do you have any disease, condition, or problem not listed above that you think I should know about?
❒	❒	If yes, explain ______________________________

DENTAL HISTORY

		YES	NO
1.	What is your chief complaint concerning your teeth or mouth?______________________		
2.	Do you have dental examinations on a routine basis?	☐	☐
	Last visit ______________________		
3.	Have you seen a Dental Specialist for any reason?	☐	☐
	______________________		
4.	Would you describe your present dental health as good?	☐	☐
5.	Do you think you have active decay or gum disease?	☐	☐
6.	Do you brush and floss on a routine basis?	☐	☐
	Discuss ______________________		
7.	Do you feel nervous about having dental treatment?	☐	☐
	Why______________________		
8.	Have you ever had a bad experience in a dental office?	☐	☐
	Describe ______________________		
9.	What are your goals of dental treatment?	☐	☐
	______________________		
10.	Do you like your smile? (If not, why?)	☐	☐
	______________________		
11.	Do your gums bleed when brushing or flossing?	☐	☐
12.	Are your teeth sensitive to hot or cold liquids/food?	☐	☐
13.	Do you feel pain to any of your teeth?	☐	☐
14.	Do you have any sores or lumps in or near your mouth?	☐	☐
15.	Have you had any head, neck or jaw injuries?	☐	☐
16.	Do you have frequent headaches?	☐	☐
17.	Do you clench or grind your teeth?	☐	☐
18.	Do you bite your lips or cheeks frequently?	☐	☐
19.	Have you ever experienced any of the following problems in your jaw?		
	a) Clicking? Popping?	☐	☐
	b) Pain (joint, ear, side of face)?	☐	☐
	c) Difficulty in opening or closing?	☐	☐
	d) Difficulty in chewing?	☐	☐

I have completed this medical/dental questionnaire to the best of my knowledge. If I ever have any change, I will inform the doctor.

Signature ______________________________________ Date ______________
(Patient, or Guardian/Parent)

Reviewed by Dr.______________________________________ Date ______________