Sandhills Periodontics

PERIODONTICS, LASER, AND IMPLANT DENTISTRY

Sohee K. Park, DMD, MHS | Diplomate of the American Board of Periodontology

Patient name _____ **Date**_____

DENTAL HISTORY

General dentist:_____

Date of last dental examination:_____Date of last dental cleaning:_____

1.	Do you have any current dental complaints?_____		
2.	Are you satisfied with the appearance of your teeth?	Yes	No
3.	Would you be tremendously disturbed if you had to lose all your teeth?	Yes	No
4.	Did either of your parents lose all of their natural teeth?	Yes	No
5.	Have you ever seen a periodontist before?	Yes	No
6.	Do your gum tissues bleed?	Yes	No
7.	Do you form tartar or plaque rapidly or been told that you do?	Yes	No
8.	Have you noticed bad odors or tastes in your mouth?	Yes	No
9.	What type of toothbrush do you use? Soft?___ Medium?___ Hard?___ Manual?___ Electric?___		
10.	What else do you use to clean your teeth?_____		
11.	Do foods wedge between your teeth?	Yes	No
12.	Are your teeth sensitive to thermal temperatures (hot, cold) or to sweets?	Yes	No
13.	Do you have any abnormal lesions in your mouth?	Yes	No
14.	Does your mouth frequently become dry?	Yes	No
15.	Do you frequently breathe through your mouth?	Yes	No
16.	Do you clench or grind your teeth during the day or night?	Yes	No
17.	Do you chew on one side of your mouth?	Yes	No
18.	Do you currently wear a bite splint (nightguard)?	Yes	No
19.	Have you ever worn braces?	Yes	No
20.	Have you ever had a frightening experience with dentistry?	Yes	No
21.	Do you feel nervous when having dental treatment?	Yes	No
22.	Does the fear of pain make you postpone dental treatment?	Yes	No
23.	Would you like to use laughing gas or moderate IV sedation?	Yes	No
24.	Is it important to you to keep your teeth?	Yes	No
25.	Would you spend 15 minutes a day to keep your natural teeth?	Yes	No

MEDICAL HISTORY

Medical Doctor:_____Phone: ( )_____

Date of last physical examination:_____

Have there been any changes in your general health during the last year? Yes No

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Patient Name_____ **Date**_____

Medical History (continued)

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

Heart Murmur/ Mitral Valve Prolapse	Yes	No	Chest Pain	Yes	No
Rheumatic Fever	Yes	No	Shortness of Breath	Yes	No
Rheumatic Heart Disease	Yes	No	Sinus Trouble/ Hayfever	Yes	No
Cardiovascular Disease/ Heart Disease	Yes	No	Hives/ Skin Rash	Yes	No
Congenital Heart Lesions	Yes	No	Tuberculosis	Yes	No
Heart Attack	Yes	No	Persistant Cough	Yes	No
High Blood Pressure	Yes	No	Swollen Ankles	Yes	No
Pacemaker	Yes	No	Osteoporosis	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	HIV/ AIDS	Yes	No
Seizures/ Fainting Spells	Yes	No	Anemia/ Blood Disorders	Yes	No
Asthma	Yes	No	Excessive Bleeding	Yes	No
Artificial Valves/ Joints	Yes	No	Stomach Ulcers	Yes	No
Hepatitis/ Jaundice	Yes	No	Condition Requiring Steroids	Yes	No
Thyroid Disease	Yes	No	Venereal Disease	Yes	No
Anxiety	Yes	No	Kidney Disease	Yes	No
Psychiatric Treatment/ Counseling	Yes	No	Cancer	Yes	No
			Do you take blood thinners?	Yes	No
			Coumadin Aspirin Other		

Do you use tobacco? Yes No

How many packs of cigarettes per day (half-pack, one pack, two packs)?

Pipe_____Cigars_____Snuff_____

Have you ever been diagnosed with glaucoma? Yes No

If yes, do you have narrow angle or wide angle glaucoma? _____

Are you taking or have you taken medications for osteoporosis i.e. Fosamax, Actonel, or Boniva? Yes No

Are you currently being treated by a physician for any other medical condition? Yes No

If yes, for what reason?

_____

Have you ever been advised to be premedicated with antibiotics prior to any dental work? Yes No

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Patient Name _____ **Date** _____

Medical History (continued)

Are you taking any drugs, medicine, or pills prescribed by a doctor or over the counter? Yes No
If yes, what medications?_____
_____
_____

Are you allergic to any medication?_____
_____

Have you recently had any serious illnesses or operations: Yes No
If yes, what kind?_____
_____

Have you ever had any problems with surgery or anesthesia? Yes No
If yes, what was the nature of the problem? _____
_____

Have you ever had abnormal bleeding with extractions, surgery, or trauma? Yes No
Do you bruise easily? Yes No
Have you ever required a blood transfusion? Yes No
Are you short of breath after climbing one flight of stairs? Yes No
Have you had surgery or radiation for a tumor or malignancy? Yes No
Have you recently gained or lost an excessive amount of weight? Yes No

Women: Are you pregnant? Yes No
Do you take birth control pills? Yes No
Are you nursing? Yes No
Have you been through menopause? Yes No

Patient's Signature:_____Date:_____

Medical/Dental History Reviewed By:_____Date:_____

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