Mountaineer Periodontics
Board Certified in Periodontics and Dental Implant Surgery

Answer to all questions are for office use only and are restricted confidential.

NAME_____ SPOUSE'S NAME_____

ADDRESS_____ CITY_____ ZIP_____

SOC. SEC.#_____ AGE_____ BIRTH DATE_____ HOME PHONE_____

BUSINESS PHONE_____ CELL PHONE_____

PATIENT'S EMPLOYER_____ OCCUPATION_____

SPOUSE'S DOB_____ DENTAL INSURANCE CO._____

SPOUSE'S EMPLOYER _____ SPOUSE'S SOCIAL_____

REFERRED BY_____ PHYSICIAN'S NAME:_____

PHYSICIAN'S ADDRESS_____PHYSICIAN'S PHONE_____

WEIGHT_____ HEIGHT_____ DATE OF LAST PHYSICAL EXAM_____

EMAIL_____

MEDICAL HISTORY

Mark an "x" in the box next to any of the following illnesses you now have or have ever had:

- ☐ Arthritis or Rheumatism
- ☐ Heart/Circulation Problems
- ☐ Diabetes
- ☐ Hives or Rashes
- ☐ Emphysema
- ☐ Liver Disease
- ☐ Nervous Exhaustion
- ☐ Rheumatic Fever
- ☐ Allergies
- ☐ Bladder Infections
- ☐ Kidney Disease or Infections
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Hepatitis
- ☐ Anemia or Blood Diseases
- ☐ Stomach Problems-Ulcers
- ☐ High Blood Pressure/Stroke
- ☐ Thyroid Disease
- ☐ Asthma or Hay Fever
- ☐ Sinus Trouble
- ☐ Epilepsy
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ Aids
- ☐ Latex Allergy

Mark an "x in the box next to any medicines that you are now taking or that you have a reaction to:

	TAKING	REACTION		TAKING	REACTION
Insulin	☐	☐	Water Pill (Diuretic)	☐	☐
Penicillin	☐.	☐	Heart Medication	☐.	☐
Other Antibiotics	☐.	☐	Antacids	☐.	☐
Aspirin.	☐.	☐	Cold Tablets	☐.	☐
Codeine	☐.	☐	Blood Pressure Med.	☐.	☐
Demerol.	☐.	☐	Anesthetics	☐.	☐
Codeine	☐.	☐	Tranquilizers	☐.	☐
Stimulants	☐.	☐	Anticoagulants.	☐.	☐
Cortisone	☐.	☐	(Blood Thinners)		
Dilantin	☐.	☐	Antihistamines	☐.	☐

Please give the name of your medication and dosage

_____
_____
_____
_____

CONTINUED ON NEXT PAGE

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(circle correct answer)

YES NO Do you smoke? How much? _____

YES NO Do you consume alcoholic beverages? How much?_____

YES NO How long have you known about your gum condition?_____

YES NO Do you have skin problems?

YES NO Have you or any member of your family had any bleeding problems?

YES NO Have you had prolonged bleeding after surgery or tooth extraction?

YES NO Have you had convulsions or fainting spells?

YES NO Do you wake with unusual thirst or need to urinate?

YES NO Do you have headaches more than once a week?

YES NO Do you have any cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion)?

YES NO Have you been bothered by a thumping or racing heart?

YES NO Does every little effort leave you short of breath?

YES NO Do you have damaged heart valves or artificial valves?

YES NO Have you ever been told you have a heart murmur?

YES NO Have you ever had surgery or radiation treatment for a tumor or growth?

YES NO Have you been under a physicians care within the past year? For what reason?_____

YES NO Are you now under the care of a physician?

If so, what condition is being treated?_____

YES NO Have you ever been hospitalized for any serious medical illness or operation?

For what reason?_____

YES NO Have you ever had a prosthetic implanted (heart valve, joint)?

ORAL HISTORY

Name of your general dentist_____

Chief Dental Complaint at the moment (what brought you here):_____

YES NO Do your gums ever bleed when you brush your teeth?

YES NO Do you ever have a bad taste in your mouth?

YES NO Are your gums receding (root exposure)?

YES NO Are your teeth sensitive to hot or cold?

YES NO Have you ever had Trenchmouth or Vincent's infection?

YES NO Do you suffer from pain and/or swelling of your gums (abcesses)?

YES NO Have you ever noticed drifting of your teeth?

YES NO Do you ordinarily place foreign objects between your teeth?

YES NO Do you bite your lip?_____. Tongue?_____. Cheek?_____

YES NO Have you noticed any loosening of your teeth?

YES NO Have you ever had your teeth straightened?

CONTINUED ON NEXT PAGE

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YES NO Do you feel your teeth come together evenly?_____ Does one tooth hit before the other?_____

YES NO Do you ever find yourself clenching and/or grinding your teeth?

YES NO Are you conscious of sore teeth?_____ High or rough fillings?_____ Rough teeth?_____

YES NO Have you ever had an occlusal adjustment or your teeth ground to improve your bite?

YES NO Have you ever had a bad reaction to dental anesthetic (Novacaine)?

YES NO Have you ever had any complications following dental surgery?

YES NO Do you gag easily?

YES NO Do you have trouble relaxing during a dental visit?

What concerns you most about your teeth?_____

How important are your teeth to you?_____

How often do you have your teeth cleaned by a dentist or hygienist?_____ Last time?_____

YES NO Do you know what dental/bacterial plaque is?

How often do you brush your teeth? _____ Type of brush?_____

When do you brush your teeth? _____

How do you clean between your teeth? _____ How often?_____

YES NO Do you floss? _____ Toothpicks? _____ Other aids? _____

FOR WOMEN ONLY

YES NO Are you taking birth control pills?

YES NO Have you gone through or are presently going through menopause?

YES NO Are you pregnant or trying to become pregnant at the present time?

COMMENTS:

I understand that if I cancel an appointment without giving at least twenty-four (24) hours notice I will be billed $50. I agree to pay this broken appointment fee within 30 days of the date of the broken appointment.

I certify that the above health history is accurate and I will notify you of any change in my physical condition.

_____ _____

Signature Date

UPDATE_____ UPDATE_____ UPDATE_____ UPDATE_____