

# PERIODONTAL PATIENT INFORMATION QUESTIONNAIRE

Name \_\_\_\_\_ Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Cell Ph # \_\_\_\_\_  
 Home \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Ph # \_\_\_\_\_  
 Marital Status: S M W D # Of Children \_\_\_\_\_ Drivers Lic. # \_\_\_\_\_ Email \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_  
 Spouse's Name (Parent Or Guardian If A Minor) \_\_\_\_\_ Occupation \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Address \_\_\_\_\_ Business Ph# \_\_\_\_\_  
 Spouse's Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_  
 Referred By \_\_\_\_\_ Current Dentist \_\_\_\_\_ How Long? \_\_\_\_\_  
 Family Physician \_\_\_\_\_ City \_\_\_\_\_ Date Of Last Physical Exam \_\_\_\_\_  
 Physician's Phone # \_\_\_\_\_ Name Of Nearest Relative (Not Living With You) \_\_\_\_\_ Phone \_\_\_\_\_

## ORAL HISTORY

1. Present dental complaint? \_\_\_\_\_ YES / NO
2. Do your gums bleed? If so when? \_\_\_\_\_ ☐ ☐
3. Have you ever had a gum boil? \_\_\_\_\_ ☐ ☐
4. Are your gums sore or swollen? \_\_\_\_\_ ☐ ☐
5. Do you have an unpleasant taste or odor in your mouth? \_\_\_\_\_ ☐ ☐
6. Are you missing any teeth? YES / NO Reason: Cavities ☐ Gum Disease ☐ Were teeth replaced? \_\_\_\_\_ ☐ ☐
7. When were teeth last cleaned? \_\_\_\_\_ How long before that? \_\_\_\_\_
8. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_  
 Hand toothbrush ( ) Electric ( ) Is it: Soft ( ) Medium ( ) Hard ( )
9. Are your teeth sensitive? \_\_\_\_\_ ☐ ☐
10. Have you ever had orthodontic treatment (braces)? \_\_\_\_\_ ☐ ☐
11. Have you had periodontal treatment previously? YES / NO By whom? \_\_\_\_\_

## HEALTH HISTORY

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ How is your general health? Good / Fair / Poor
2. Are you now being treated or have you been treated within the last year by a physician? \_\_\_\_\_ ☐ ☐
3. If yes, please indicate for what \_\_\_\_\_
4. Have you ever had any surgery? \_\_\_\_\_ ☐ ☐
5. Are you now taking any medication, drugs, or pills? \_\_\_\_\_ ☐ ☐
- If yes, please list those drugs \_\_\_\_\_
6. Have you taken cortisone or steroids within the last year? \_\_\_\_\_ ☐ ☐
7. Have you ever experienced an **allergic** or **adverse** reaction to any of the following?  
 Aspirin: YES / NO Sleeping pills: YES / NO LATEX ALLERGY: YES / NO  
 Codeine: YES / NO Penicillin: YES / NO Dental anesthetics (Novocaine): YES / NO  
 Other drugs, antibiotics or medications? If yes, please list: \_\_\_\_\_
8. Are you taking or have you ever taken Bisphosphonates for Osteoporosis, Multiple Myeloma or other cancers?  
 (Such as: Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) \_\_\_\_\_ ☐ ☐
9. Do you take Pre-medication prior to your dental procedure for joint replacement or your heart? \_\_\_\_\_ ☐ ☐
10. Have you ever had?: YES / NO YES / NO YES / NO  

Heart trouble..... <input type="checkbox"/> <input type="checkbox"/>	Radiation Therapy..... <input type="checkbox"/> <input type="checkbox"/>	Epilepsy..... <input type="checkbox"/> <input type="checkbox"/>
Heart attack..... <input type="checkbox"/> <input type="checkbox"/>	Diabetes Type I / II..... <input type="checkbox"/> <input type="checkbox"/>	Convulsions..... <input type="checkbox"/> <input type="checkbox"/>
Heart murmur..... <input type="checkbox"/> <input type="checkbox"/>	If so, what is your HB/A1C.....	Arthritis..... <input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever..... <input type="checkbox"/> <input type="checkbox"/>	HIV Positive/AIDS..... <input type="checkbox"/> <input type="checkbox"/>	Joint Replacement..... <input type="checkbox"/> <input type="checkbox"/>
High blood pressure..... <input type="checkbox"/> <input type="checkbox"/>	Venereal Disease..... <input type="checkbox"/> <input type="checkbox"/>	Hepatitis (liver disease)..... <input type="checkbox"/> <input type="checkbox"/>
Stroke/TIA..... <input type="checkbox"/> <input type="checkbox"/>	Thyroid or Parathyroid trouble..... <input type="checkbox"/> <input type="checkbox"/>	Jaundice..... <input type="checkbox"/> <input type="checkbox"/>
Bleeding Problems..... <input type="checkbox"/> <input type="checkbox"/>	Asthma..... <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal Disorder..... <input type="checkbox"/> <input type="checkbox"/>
Anemia or any abnormal blood counts... <input type="checkbox"/> <input type="checkbox"/>	Lung Disease..... <input type="checkbox"/> <input type="checkbox"/>	Ulcers..... <input type="checkbox"/> <input type="checkbox"/>
Cancer, Tumor or Growth..... <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis..... <input type="checkbox"/> <input type="checkbox"/>	Kidney Disease..... <input type="checkbox"/> <input type="checkbox"/>
11. Do you get up often at night to urinate? \_\_\_\_\_ ☐ ☐
12. Are you thirsty much of the time? \_\_\_\_\_ ☐ ☐
13. Has anyone in your family had diabetes? \_\_\_\_\_ ☐ ☐
14. Do you consider yourself a nervous person? \_\_\_\_\_ ☐ ☐
15. Do you smoke? \_\_\_\_\_ ☐ ☐
16. FEMALES Are you taking birth control pills? YES / NO Are you pregnant at the present time? YES / NO If Yes, what month? \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_ Dr.'s Initials \_\_\_\_\_