LETHBRIDGE PERIODONTAL ASSOCIATES

HEALTH HISTORY

Name ______________________________

Height ______________ Weight ______________ Date of Birth ______ (DAY MONTH YEAR)

Home Address ______________ City ______________ Postal Code ______________

Telephone: Cell ______________ Home ______________ Business ______________

Marital Status (Please circle): Single Married Divorced. Name of Spouse ______________ Date of Birth ______ (DAY MONTH YEAR)

Patient's occupation ______________ Firm ______________

Spouse's occupation ______________ Firm ______________

Patient's A.H.C. # ______________ Email ______________

Patient's dentist ______________________________

How long have you been a patient of your present dentist? ______________

Name of Dental Insurance Company (if any): Name ______________ Group ______ Cert ______

Dual Plan/Spouse Plan: Name ______________ Group ______ Cert ______

Date of last physical examination ______________ Findings ______________

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Periodontal disease may be caused by a combination of several factors and the following questions are designed to help us identify them. The success of therapy is dependent upon this. Therefore, although some of the following questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health and are confidential.

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CIRCLE ONE
*DK - Don't Know

1. Are you now or have you ever been under the care of a physician for a certain condition? .... Yes No DK

____

2. Do you have or suspect you have Acquired Immune Deficiency Syndrome? .... Yes No DK
3. Are you taking or have you taken any drugs within the past year? .... Yes No DK
   (example: tranquilizers, steroids, aspirin) List ______________
4. Do you have any in dwelling medical devices (hip or knee replacement, heart valve or pacemaker, etc.)? .... Yes No DK
5. Do you have or have you ever had any of the following conditions:

Condition			
Asthma	Yes	No	DK
Rheumatic Fever	Yes	No	DK
Heart Murmur	Yes	No	DK
Heart problems	Yes	No	DK
Heart attack	Yes	No	DK
High blood pressure	Yes	No	DK
Heart surgery	Yes	No	DK
Stroke	Yes	No	DK
Scarlet fever	Yes	No	DK
Anaemia	Yes	No	DK
Abnormal blood count	Yes	No	DK
Hay fever	Yes	No	DK
Hives or skin rash	Yes	No	DK
Tumor or growth	Yes	No	DK
Frequent headaches	Yes	No	DK
Sinusitis	Yes	No	DK
Radiation therapy	Yes	No	DK
Lupus	Yes	No	DK
Tendency to faint	Yes	No	DK
Epilepsy	Yes	No	DK
Diabetes	Yes	No	DK
Seizures or convulsions	Yes	No	DK
Jaundice	Yes	No	DK
Hepatitis (liver disease)	Yes	No	DK
Thyroid or Parathyroid disorder	Yes	No	DK
Kidney problems	Yes	No	DK
Arthritis or Rheumatism	Yes	No	DK
Ulcers	Yes	No	DK
Tuberculosis	Yes	No	DK
Emphysema	Yes	No	DK
Herpes	Yes	No	DK
Glaucoma	Yes	No	DK
Prostate disorders	Yes	No	DK

(Over)

6. Has your general health changed in the past year? .... Yes No DK

7. Has your weight changed in the past year? .... Yes No DK

8. Have you ever had any serious illnesses or major operations? .... Yes No DK

9. Have you had abnormal bleeding associated with previous tooth extraction, surgery, or trauma? .... Yes No DK

10. Do you heal slowly? .... Yes No DK

11. Have you ever had any allergies (food, dust, drugs, fur, latex, etc.)? .... Yes No DK

12. Are you allergic or have you had an adverse reaction to any of the following:

Dental anaesthetics (novocaine, etc)	Yes	No	DK	Aspirin	Yes	No	DK
Penicillin or other antibiotics	Yes	No	DK	Codeine	Yes	No	DK
Barbiturates (sleeping pills)	Yes	No	DK	Other drugs	Yes	No	DK
Peanut Allergy	Yes	No	DK				

13. Have you ever been warned against taking any drug or medicine? .... Yes No DK

14. Have you ever had an asthmatic attack? .... Yes No DK

15. Are you ever short of breath or have chest pains after mild exertion? .... Yes No DK

16. Do your ankles swell? .... Yes No DK

17. Are you thirsty much of the time? .... Yes No DK

18. Has anyone in your family ever had diabetes? Who? .... Yes No DK

19. Do you have a persistent cough or do you cough up blood? .... Yes No DK

20. Do you consider yourself a nervous person? .... Yes No DK

21. Have you ever received psychiatric care? Psychotherapy? .... Yes No DK

22. Have you ever had surgery or treatment for a tumor or growth of your head, mouth or lips? .... Yes No DK

23. Do you smoke or have you ever smoked or used other tobacco products? .... Yes No DK

If yes, how long?____________________ Date quit? ____________________

24. Do you often consume more than two alcoholic drinks per day? .... Yes No DK

DENTAL HISTORY

25. What is your reason for coming to this office? ____________________

____

26. Are you experiencing pain from your mouth at this time? Lately? .... Yes No DK

27. Have you had any swollen areas of the gums? .... Yes No DK

28. Have your gums been receding? .... Yes No DK

29. Have your gums been bleeding? When? .... Yes No DK

DENTAL HISTORY

30. Have you noticed bad mouth odors or tastes? .... Yes No DK

31. Have you, in the past, ever had periodontal(gum) treatments? When and by whom? ____________ Yes No DK

____

32. When did you last have your teeth cleaned? ____________

33. How often have you had your teeth cleaned in the last ten years? ____________

34. Have your front teeth separated, creating spaces between them lately? .... Yes No DK

35. Have you noticed any loose teeth? .... Yes No DK

36. Does food catch between your teeth? .... Yes No DK

37. Have you ever been told that you have periodontal disease or pyorrhea? .... Yes No DK

38. Do you clench or grind your teeth during the day or night? .... Yes No DK

39. Do you bite your lip, tongue or cheek? .... Yes No DK

40. Do you feel that your teeth come together evenly? .... Yes No DK

41. Are you conscious of sore teeth, loose teeth, or high fillings? .... Yes No DK

42. How often do you brush your teeth ______1, ______2, ______3, ______ or more times a day?

43. Do you use a hard, medium, or soft tooth brush? (PLEASE CIRCLE)

44. What home care aids are you currently using?
e.g. dental floss, stimudents, water pik, rubber tip, proxy brush, mouthwash or electric toothbrush (PLEASE CIRCLE)

45. Would you be tremendously disturbed if you had to lose your teeth and wear false teeth? .... Yes No DK

46. Would you be willing to spend several minutes per day cleaning your teeth? .... Yes No DK

47. Are you satisfied with the appearance of your teeth? .... Yes No DK

48. Have you ever had orthodontic treatment (braces)? .... Yes No DK

49. Do you breathe primarily through your mouth? .... Yes No DK

50. Have you ever had an extremely frightening experience with dentistry? .... Yes No DK

FOR WOMEN ONLY

51. Are you pregnant at the present time? ____________ Expected due date ....

52. Date of last menstrual period ____________

53. Have you reached menopause? .... Yes No DK

54. Have you had a hysterectomy or ovariectomy? .... Yes No DK

55. Are you taking female hormones (oral contraceptives, etc.) .... Yes No DK

56. Do you know that certain medications (e.g. antibiotics) may inhibit the effectiveness of oral contraceptives? .... Yes No DK

I hereby give consent to have a periodontal (dental) examination and or relief of pain treatment. This treatment may include use of various medications such as: local anaesthetics (freezing), antibiotics, analgesics (pain killers), and others as required.

DATE: ____________ SIGNED ____________
Parent or Guardian if Under Legal Age