EASTSIDE
PERIODONTICS | IMPLANTS

General Health Information

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Has there been a change in your general health in the last year? ☐ Yes ☐ No
Physician's Name:_____ City_____ Phone #:_____
Date of last physical examination: Month_____ Year_____ Currently under treatment by a physician? ☐ Yes ☐ No
Please explain_____
Do you engage in regular exercise? ☐ Yes ☐ No Type_____
Have you every taken a bisphosphonate (Fosamax, Actonel, Boniva, etc.) for osteoporosis? ☐ Yes ☐ No
Do you need to take antibiotics prior to receiving dental or surgical care? ☐ Yes ☐ No ☐ Don't know

Major hospitalizations, surgeries and blood transfusions: ☐ Mark here if none

Date (Month/Year)	Reason
_____	_____
_____	_____
_____	_____

Allergic or Unusual Reaction to any of the Following: ☐ Mark here if none

☐ Penicillin
☐ Sulfa drugs
☐ Aspirin
☐ Local Anesthesia
☐ Opiates (codeine, etc.)
☐ Iodine
☐ Latex
☐ Barbiturates, sedatives, etc.
☐ Other drugs:_____
☐ Other substances (food, metals, etc.):_____

Women Only ☐ Not Applicable

Are you: ☐ Pregnant?_____weeks ☐ Trying to become pregnant? ☐ Not sure if you are pregnant?
☐ Using birth control pills? ☐ Going through menopause? ☐ Post-menopausal

Prescription/Non Prescription Medications: ☐ Mark here if none

List all medications and herbal supplements/remedies that you are currently taking.

Name	For what condition?	Dose/frequency of use
1)		
2)		
3)		
4)		
5)		
6)		

Medical History: Past and Present Illness

Please mark the boxes next to the conditions that you currently have or have had in the past.

General
☐ Weight loss_____lbs. Over what time period?_____
☐ Weight gain_____lbs. Over what time period?_____
☐ Loss of appetite ☐ Always hungry
☐ Always thirsty ☐ Frequent urination
☐ Fatigue ☐ Night sweats
☐ Bleed easily ☐ Bruise easily

Hormonal or Metabolic Disorders
☐ Diabetes ---------- ☐ Type I ☐ Type II
-Last HbA1C_____ Date_____
☐ Thyroid problems ☐ Adrenal insufficiency
☐ Other_____

Immune System Disorder
☐ Rheumatoid arthritis ☐ Lupus erythematous
☐ Sjogren's Syndrome ☐ Other_____

Cancer & Neoplastic Disease
☐ Cancer_____
☐ Leukemia ☐ Lymphoma

Musculoskeletal
☐ Joint pain ☐ Swollen joints
☐ Muscle cramping ☐ Other_____

Other Major Organ Disease
☐ Kidney disease ☐ Liver disease
☐ Organ transplant ☐ Spleen surgery
☐ Other_____

Other Conditions
☐ Prosthetic valve (which valve_____ date_____)
☐ Prosthetic joint (where_____ date _____)
☐ Disabled_____ ☐ Other_____

Head and Neck Conditions
☐ Injury to face, jaws, neck ☐ Concussion
☐ Radiation treatment ☐ Sinusitis
☐ TMJ problems ☐ Salivary gland problems
☐ Facial pain ☐ Jaw pain
☐ Neck swelling/pain ☐ Other_____

Infectious Diseases
☐ Sexually transmitted diseases_____
☐ HIV/AIDS ☐ Other_____

Chronic Pain
☐ Back ☐ Abdominal
☐ Headache ☐ Migraine
☐ Other_____

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Medical History: Past and Present Illness (Continued)

Neurologic Disorders
☐ Epilepsy/seizures ☐ Neuralgia
☐ Stroke ☐ Paralysis/weakness
☐ Dizzy/fainting spells ☐ Other_____

Cardiovascular (Heart/Blood Disorders)
☐ High blood pressure ☐ Heart attack
☐ Coronary artery disease ☐ Heart murmur
☐ Heart valve problems ☐ Atherosclerosis
☐ Bleeding disorder ☐ Anemia
☐ Shortness of breath ☐ Swollen ankles
☐ Racing or irregular heartbeat ☐ Chest pain/angina

Respiratory (Lung/Airway Disorders)
☐ Emphysema ☐ Pneumonia
☐ Bronchitis ☐ Asthma
☐ Tuberculosis ☐ Sleep apnea
☐ Coughing spells ☐ Wheezing

Gastrointestinal
☐ Acid-reflux/heartburn ☐ Ulcer/gastritis
☐ Bowel problems/colitis ☐ Nausea/vomiting

Skin Disorders
☐ Skin cancer ☐ Skin infections
☐ Skin/nail changes ☐ Other_____

Eyes/Ears/Nose/Throat
☐ Glaucoma ☐ Nose bleeds
☐ Nasal obstructions ☐ Mouth breathing/snoring
☐ Other_____

Behavioral Conditions
☐ Psychiatric illness ☐ Anxiety/panic attacks
☐ Depression ☐ Stress
☐ Other_____

Family Medical History
Please mark the box beside the medical problems that have been present in your parents, brothers, sisters, or close relatives.

☐ Genetic (inherited) disease ☐ Liver/kidney disease
☐ Immune system disease ☐ Diabetes
☐ Bleeding disorders ☐ Tuberculosis
☐ Neurologic disease ☐ Heart conditions
☐ Other (include cancer)_____

Social History

Number of caffeinated beverages you drink in a day: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 5+
Number of alcoholic beverages you drink in a week: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 10+
Number of carbonated beverages a day: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 5+
Previous (or current) substance abuse? ☐ No ☐ Yes Type_____
Have you ever used tobacco? ☐ No ☐ Yes
If yes, what type: ☐ Cigarette ☐ Pipe/Cigar ☐ Smokeless
If yes, number of uses per day?_____ For how many years?_____
If yes, are you interested in quitting? ☐ No ☐ Yes ☐ Quit_____

Dental History

Do you consider yourself in good dental health? ☐ Yes ☐ No
Has your dental care been: ☐ Regular ☐ Sporadic
☐ Last visit_____ Reason for last visit_____
How many times a day do you brush your teeth? ☐ Zero ☐ Once ☐ Twice ☐ 3 or more
How frequently do you floss? ☐ Daily ☐ 1-3/Week ☐ 3-5/Week ☐ Never
Do you think that your teeth are affecting your health in any way? ☐ Yes ☐ No
Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
Are you dissatisfied with your chewing ability? ☐ Yes ☐ No
Have you had any of the following?
☐ Orthodontic Treatment (Braces) When_____ Doctor_____
☐ Oral Surgery (Extractions, etc.) When_____ Doctor_____
☐ Periodontal Treatment
☐ Scaling and Root Planing ("deep cleaning") When_____ Doctor_____
☐ Surgical Treatment When_____ Doctor_____
Have you noticed any loosening of your teeth? ☐ Yes ☐ No
Does food tend to get caught between your teeth? ☐ Yes ☐ No
Do you suffer from pain and/or swelling of your gums? ☐ Yes ☐ No
Do your gums often bleed when you brush your teeth? ☐ Yes ☐ No
Do you have an unpleasant odor or taste in your mouth? ☐ Yes ☐ No
Are you missing any teeth? ☐ Yes ☐ No
Reasons: ☐ Decay ☐ Broken ☐ Gum Disease ☐ Other_____
Do you have soreness, pain, clicking or popping in your jaw? ☐ Yes ☐ No
Are you anxious about receiving dental treatment? ☐ Yes ☐ No
Please rate your anxiety level: ☐ Extremely anxious ☐ Moderately anxious ☐ Slightly anxious
Do you have a family history or periodontal disease? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my medical history or medications, I will inform the doctor.

Signature_____ Date_____