PATIENT HEALTH HISTORY

Date _____

Welcome to South Hill Periodontics! We appreciate the confidence you have in us to provide your periodontal needs. To assist us in serving you, please complete the following form. The information is important to your care. If there is any changes in your health, please tell us. We are always available to answer any of your questions.

Patient Name _____ Date of Birth _____ Age _____

Physician's Name _____ Date of Last Visit to Physician _____

Dentist's Name _____ Date of Last Visit to Dentist _____

Height _____ Weight _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems

- ☐ Chest Pain
- ☐ Blood Pressure Problem
- ☐ Heart Murmur
- ☐ Heart Valve Disorder (e.g., MVP)
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Previous Heart Attack
- ☐ Fast Heart Rate
- ☐ Other _____

Blood Problems

- ☐ Bruise Easily
- ☐ Abnormal Bleeding
- ☐ Blood Disease (e.g. anemia)
- ☐ Other _____

Allergy Problems

- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Other _____

Intestinal Problems

- ☐ Ulcer
- ☐ Hiatal Hernia/GERD
- ☐ Other _____

Bone or Joint Problems

- ☐ Arthritis
- ☐ Joint Replacement (e.g., total hip)
  Date _____
- ☐ Other _____

Lung/Breathing Problems

- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Problems Laying Flat
- ☐ Sleep Apnea
- ☐ Other _____

Liver Problems

- ☐ Hepatitis
- ☐ Jaundice
- ☐ Other _____

Other Medical Problems

- ☐ Fainting Spells, Seizures, Epilepsy, or Stroke
- ☐ Diabetes
- ☐ HIV Positive
- ☐ Glaucoma
- ☐ Cancer/Tumor
- ☐ Radiation Treatment
- ☐ Surgery in the last 6 months
  Date & Type _____

Social History

- ☐ Do you drink? If so, how much? _____
- ☐ Do you smoke? If so, how much? _____
  How many years? _____
- ☐ Do you chew tobacco? How often? _____

Are you allergic or have you had a reaction to any of the following?

- ☐ Local anesthetics ("Novocaine")
- ☐ Penicillin
- ☐ Other Antibiotics _____
- ☐ Aspirin
- ☐ Codeine
- ☐ Valium
- ☐ Demerol
- ☐ Other _____

List of Medications including low dose aspirin, fish oil, Krill or herbs.

_____

_____

_____

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_____

_____

Women

- ☐ Are you taking contraceptives?
- ☐ Hormone Replacement Therapy?
- ☐ Is there a possibility you may be pregnant?
  No _____
  Yes_____ Date of Delivery_____

DENTAL HEALTH HISTORY

Please Mark Any That Apply to You

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had previous periodontal treatment?
- ☐ Do your gums bleed when you brush and floss?
- ☐ Do your gums feel swollen or tender?
- ☐ Are your teeth sensitive?
- ☐ Do you prefer to save your teeth?
- ☐ How often do you brush?_____ How often do you floss? _____
- ☐ Type of Brush: Standard _____ Sonicare_____ Other (electric) _____
- ☐ Does your jaw make noise?
- ☐ Do you clench or grind your teeth?
- ☐ Does your jaw get stuck so that you cannot open freely?
- ☐ Do you have any jaw symptoms or headaches?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- ☐ Do you have a temporomandibular joint disorder (TMD, TMJ)?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Are you a habitual gum chewer or pipe smoker?
- ☐ Do you have any disease, condition, or problem not listed previously that you feel we should know about?

  If so please describe:_____

Date:_____ Patient Signature: _____ Dr. Signature:_____

DENTIST COMMENTS

Date	Blood Pressure Reading	Medical History Updated
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____