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PATIENT MEDICAL HISTORY – C O N F I D E N T I A L

The connection between **periodontal disease** and other health issues has been firmly established. In order for Dr. Burdine to better understand and evaluate your periodontal condition, please answer the following questions completely and accurately. Your answers are for our records only and will be considered confidential. This information will only be used for planning and facilitating your treatment, consulting other professionals regarding your therapy, and obtaining insurance reimbursements on your behalf, unless your written authorization for other uses is obtained.

During your initial visit with the doctor, you will have an opportunity to discuss your general health, your responses to this questionnaire, and any additional health questions you or the doctor may have.

Patient Name: _____

Social Security No: _____

Date of Birth: _____

Home Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Work Phone:** _____

E-Mail Address: _____

Notice of Privacy Practices

*I have received and understand this office's **Notice of Privacy Practices**. The notice explains what uses and disclosures of my protected health information may be made by this practice: the practice's legal duties, and my individual rights with respect to my protected health information.*
*I understand that this practice reserves the right to change the terms of its **Notice of Privacy Practices** and to make new provisions for all protected health information that it maintains.*

Date: _____

Signature: _____

Relationship to Patient (if signed by a personal representative of patient): _____

1. Yes No Are you in good health?

2. Yes No Have there been any changes in your health within the past year?

3. Date of your last physical examination: _____

4. Yes No Are you now under the care of a physician?
If so, what is the condition being treated?

_____

_____

_____

Name and phone number of your physician:

_____

5. Yes No Have you had any serious illness, operation, or been hospitalized within the past 5 years?
If so, what was the illness or problem?

_____

_____

6. Yes No Are you taking any medications, including non-prescription medications?
Please list medications and dosages.

_____

_____

_____

7. Are you allergic to, or have you had a reaction to:

a.	Yes	No	Local anesthetic	f.	Yes	No	Demerol
b.	Yes	No	Aspirin	g.	Yes	No	Codeine
c.	Yes	No	Penicillin	h.	Yes	No	Antihistamines
d.	Yes	No	Other antibiotics	i.	Yes	No	Other (please list)
e.	Yes	No	Barbiturates, sedatives, or sleeping pills				

_____

_____

8. Do you have or have you had any of the following conditions?

a.	Yes	No	Damaged heart valves, or artificial heart valves, heart murmur, or any inborn heart defects
b.	Yes	No	Heart disease (heart attack, angina, coronary problems, or congestive heart failure)
c.	Yes	No	Allergy
d.	Yes	No	Sinus trouble
e.	Yes	No	Asthma
f.	Yes	No	Persistent diarrhea, or recent weight loss
g.	Yes	No	Diabetes
h.	Yes	No	Hepatitis, jaundice, or liver disease
i.	Yes	No	Aids or HIV infection
j.	Yes	No	Thyroid problems
k.	Yes	No	Respiratory problems, emphysema, tuberculosis

l.	Yes	No	Arthritis or painful, swollen joints
m.	Yes	No	Rheumatic fever
n.	Yes	No	High blood pressure
o.	Yes	No	Stroke
p.	Yes	No	Atherosclerosis (hardening of the arteries)
q.	Yes	No	Anemia or other blood disorders
r.	Yes	No	Stomach ulcer or hyperacidity
s.	Yes	No	Kidney trouble or bladder disorder
t.	Yes	No	Persistent cough or cough that produces blood
u.	Yes	No	Persistent swollen glands in the neck
v.	Yes	No	Low blood pressure
w.	Yes	No	Sexually transmitted disease
x.	Yes	No	Epilepsy or other neurological disease
y.	Yes	No	Cancer
z.	Yes	No	Problems of the immune system

9.	Yes	No	Have you had an organ or joint replacement?
10.	Yes	No	Are you using a cardiac pacemaker?
11.	Yes	No	Are you wearing contact lenses?
12.	Yes	No	Has anyone in your family had diabetes?
			What is that person's relationship to you? _____
13.	Yes	No	Have you ever had psychiatric treatment?
14.	Yes	No	Have you ever had radiation therapy or chemotherapy?
15.	Yes	No	Have you ever been treated for any type of skin disease?
16.	Yes	No	Have you ever taken cortisone?
			If so, when and for how long? _____
17.	Yes	No	Have you ever had a bleeding problem?
18.	Yes	No	Have you ever had a blood transfusion?
19.	Yes	No	Have you ever taken anticoagulants (blood thinners)?
20.	Yes	No	Do you bruise easily?
21.	Yes	No	Are you on a special diet at this time?
			If so, why? _____
			_____
22.	Yes	No	Have you ever fainted?
23.	Yes	No	Have you ever had a seizure?
24.	Yes	No	Do you get short of breath easily?
25.	Yes	No	Do you have chest pain upon exertion?
26.	Yes	No	Do your ankles swell?
27.	Yes	No	Has a physician ever said you had stomach trouble?
28.	Yes	No	Are you considered a nervous person?
29.	Yes	No	Do you consume alcoholic beverages?
			If so, how much per day? _____
30.	Yes	No	Do you smoke or use tobacco products?
			If so, how much per day? _____
31.	Yes	No	Do you have a drug addiction or do you use recreational drugs?
32.	Yes	No	Do you tend to worry about things that do not happen?
33.	Yes	No	Do you often give up doing things (trips, parties) because of unexpectedly not feeling well?
34.	Yes	No	Do you have headaches regularly?
			mornings? evenings? (circle one or both as applicable)

Women

35. Yes No Are you pregnant?
36. Yes No Have you reached menopause?
37. Yes No Do you have any problems associated with your menstrual period?
38. Yes No Are you nursing?
39. Yes No Are you using birth control pills, injections or implants or hormone replacement of any kind?

Please include any additional health information you would like the doctor to know:

_____

_____

_____

_____

DENTAL HISTORY

40. **Chief dental concern:** _____

_____

41. Yes No Are you experiencing pain in your mouth?

If so, where? _____

42. Yes No Do you take antibiotic premedication prior to dental work?
43. How many times have you had your teeth cleaned in the past five years? _____

When was the last time? _____

44. Yes No Have you had previous periodontal treatments?

If so, where and by whom? _____

45. Yes No Do your gums bleed?
46. Yes No Have you noticed any loose or shifting teeth?
47. Yes No Have you noticed any mouth odors or bad tastes?
48. Yes No Have you ever had trench mouth?
49. Yes No Have any or your mother, father, sister or brother lost all of their natural teeth?
50. Yes No Are your teeth sensitive to:
heat? cold? sweets? pressure? (circle **all** applicable)
51. Yes No Do foods wedge between your teeth?
52. How often do you brush your teeth? _____
53. How often do you floss your teeth? _____ _____
54. Yes No Do you use a hard medium soft brush? (circle one)
55. Yes No Do you often have fever blisters on your lips?
56. Yes No Have you had your teeth straightened?
57. Yes No Would you be tremendously disturbed if you lost your teeth and had to wear dentures?
58. Yes No Are you satisfied with the appearance of your teeth?
59. What would you like to change about your mouth? _____

_____

60. Yes No Have you been under more than average stress lately?
61. Yes No Are you aware of grinding your teeth in your sleep?
62. Yes No Do you hold your teeth together?

63. Yes No **Are you aware of sensations in your jaw joints?**
Yes No **Clicking?**
Yes No **Popping?**
Yes No **Pain?**

64. Yes No **Are you wearing removable dental appliances?**

65. Yes No **Have you ever had an extremely frightening experience with dentistry?**
Please describe:

_____

_____

66. Yes No **Have I treated any of your family or friends?**

Who? _____

67. **Whom may we thank for referring you to our office?**

_____

I, _____, (print your name), the undersigned, have read and understand the above questions. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will inform Dr. Burdine of any change in my health and/or medications.

_____ _____

Signature ***Date***

Doctor's Notes:

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