GENERAL HEALTH CHART

Name ______________________________ Social Security # ______________

Address ______________ City ______________ Zip ________ Phone ____________

Age ______ Date of Birth ________ Sex ______ Height ________ Weight ________ Marital Status ____________

Occupation/Employer ____

Address ______________ City ______________ Zip ________ Phone ____________

Referred by ______________________ Insurance Carrier ______________________

Since the cause of periodontal disease is a combination of many factors, and is very complex, it is necessary to investigate any possible contributing influences. The success of treatment depends upon the control of all causative factors.

Although many of these questions may not directly involve your periodontal condition, they are all related to the successful management of your case.

Please answer all the questions to the best of your ability. Your responses are for our records only and will be kept confidential.

PRESENT HEALTH:

1. How would you describe your present health? ______________________
2. Are you now under the care of a physician? .... Yes No
3. Name and address of your physician ______________________
   ______________________ Phone ____________
   Date of last physical exam ______________________
4. What medications are you presently taking? ______________________

PAST MEDICAL HISTORY: Do you have any artificial joints? .... Yes No

5. Have you had any serious illness or operation? .... Yes No
   If so, what and when? ______________________
6. Have you ever had any allergies? .... Yes No
   If so, what and when? ______________________

CARDIOVASCULAR:

7. Have you ever had any heart trouble? ☐ murmurs? ☐ .... Yes No
8. Has your blood pressure ever been too high? ☐ too low? ☐ .... Yes No
9. Have you ever had rheumatic fever? ☐ rheumatic heart disease? ☐ .... Yes No
10. Are you subject to fainting spells? ☐ dizziness? ☐ chest pains? ☐ .... Yes No
11. Have you ever had a stroke? .... Yes No

BLOOD:

12. Have you ever had abnormal bleeding problems after a cut? ☐ tooth extraction? ☐ .... Yes No
13. Do you bruise easily? ☐ bleed easily? ☐ .... Yes No

ENDOCRINE:

14. Do you have diabetes? .... Yes No
15. Have you ever received treatment for any endocrine or glandular disorder? .... Yes No

NERVOUS:

16. Do you suffer frequent or severe headaches? .... Yes No
17. Have you ever had severe pains of head or face? .... Yes No
18. Do you consider yourself excessively nervous? .... Yes No
19. Have you ever had epilepsy or convulsions? .... Yes No
20. Have you ever had a nervous breakdown? .... Yes No

RESPIRATORY:

21. Do you ever become short of breath? .... Yes No
22. Do you have asthma? .... Yes No
23. Have you had tuberculosis or a persistant cough? .... Yes No
24. Do you smoke? .... Yes No
    If so, what and how much? ______________________

G.I. AND G.U.

25. Have you ever had hepatitis? .... Yes No
    Have you ever had stomach or duodenal ulcers? .... Yes No

26. Are you on any special diet? .... Yes No
27. Have you any kidney or liver problems? .... Yes No
28. Have you ever had syphilis, gonorrhea, or other venereal disease? .... Yes No

OTHER: Have you been tested for the AIDS virus? ______ Are you HIV positive.... Yes No

29. Are you sensitive to aspirin, penicillin, novocain, codeine or any other drug? .... Yes No
30. Have you ever received X-ray or radioactive isotope treatment? .... Yes No
31. Have you ever had a tumor or cancer? .... Yes No
32. Have you ever had local anesthesia? ☐ general anesthesia? ☐ nitrous oxide (laughing gas)? ☐ .... Yes No
33. Do you have arthritis? .... Yes No
34. Do you have any impairment or disorder of your eyes, ears, nose or throat? .... Yes No
35. Do you have recurrent herpes? .... Yes No

FEMALES:

36. Are you now pregnant or are you anticipating pregnancy within the next year? .... Yes No
37. Have you undergone, or are you presently undergoing menopause? .... Yes No
38. Are you taking birth control medication? .... Yes No

PRESENT DENTAL HEALTH:

1. Name and address of your dentist ______
   ______ Phone ______
   Date of your last visit ______
2. Do your gums bleed? .... Yes No
   If so, when? ______
3. Are you aware of a bad taste or odor in your mouth? .... Yes No
4. Does your jaw ever click or cause pain on opening or closing? .... Yes No
5. Have you noticed any shift in your teeth or bite? .... Yes No
6. Do you ever have pain in your jaw? ☐ in your ear? ☐ .... Yes No
7. Have you ever noticed yourself clenching your teeth? ☐ grinding your teeth? ☐ .... Yes No
   If so when? ______
8. Is any area of your mouth sore to pressures or irritants? .... Yes No
   If so, where and to what? ______
9. Are you in pain now? .... Yes No
   Where? ______
10. When were your last full mouth X-rays? ______
11. When did you last have your teeth cleaned? ______
    Where? ______
12. What oral hygiene aids do you use? ______
    How often? ______
13. What do you consider most important?
    preservation of natural teeth ☐ irradication of infection ☐ esthetics ☐
    elimination of pain ☐ avoidance of removable dentures ☐ function ☐
    other ______

PAST DENTAL HISTORY:

14. Have you ever had an acute sore mouth or gum boils? .... Yes No
15. Did you ever wear braces for straightening your teeth? .... Yes No
16. Have you ever been instructed in care of your gums or prevention of decay? .... Yes No
17. Have you ever had previous periodontal or gum treatments? .... Yes No
    If so, when? ______ Where? ______
18. Have you ever had a tooth removed? .... Yes No
    If so, when? ______ Why? ______
19. Have you ever had any serious problems associated with previous dental treatment? .... Yes No
    If so, explain ______

Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No

If so, please explain ______

THANK YOU FOR YOUR COOPERATION.

Signature ______

Date ______