Lawrence Periodontics, LLC

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Dental and Medical Health History

Although dentists primarily treat the area in and around your mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important impact on the treatment that you will be receiving. The following information is strictly confidential.

Name: _____ **Date of Birth:** _____ **Age:** _____

Who is the *general dentist* that you normally see?_____ For how long? _____
How often do you get your teeth cleaned? _____ When was your last cleaning? _____
How long have you know about your present gum condition? _____

Physician's Name: _____ **Date of Last Physical:** _____
Have you been hospitalized during the last two years? Yes/No _____
Have you been under a physician's care during the last two years? Yes/No _____
Are you allergic to any medications (itching, swelling, difficulty breathing) such as Penicillin, Sulfa drugs, Aspirin, NSAIDS, Codeine, Local anesthetics, latex, metals, etc ?_____
Do you use any tobacco products? Yes/ No. What tobacco product and how much? _____
Do you drink alcohol? Yes / No More than 2 drinks per day? Yes / No
Have you ever had excessive bleeding that required special treatment to stop? _____
Have you taken medication for osteoporosis (Bisphosphonates Fosamax, Actonel, Boniva, Zometa, Aredia)? Yes/No

Dental History- Do you have, or have had, any of the following?

	Yes	No		Yes	No
Does dental treatment make you nervous ?	☐	☐	Orthodontic treatment (braces)?	☐	☐
Are your gums sore or bleeding?	☐	☐	Are you satisfied with the appearance of your teeth?	☐	☐
Do you clench or grind your teeth?	☐	☐	Are there any growths or sores in your mouth?	☐	☐
Are any of your teeth loose?	☐	☐	Do you have any pain in your mouth?	☐	☐
Difficulty opening or closing jaws?	☐	☐	Have you had any bad experiences in a dental office?	☐	☐
Does your jaw pop or click?	☐	☐	Has any member of your family lost all their teeth?	☐	☐
Is your bite changing?	☐	☐	Have you ever been treated for periodontal disease?	☐	☐

Dental Oral Hygiene Tools- Do you use any of the following to take care of your teeth?

	Yes	No		Yes	No
Manual toothbrush	☐	☐	Electric toothbrush	☐	☐
Dental floss	☐	☐	Waterpik Flosser	☐	☐
Proxabrush	☐	☐	Additive to Waterpik	☐	☐
Tooth picks	☐	☐	Fluoride Rinse	☐	☐
Stimudents	☐	☐	Oral rinse	☐	☐
Rubber tip stimulator	☐	☐	Fluoridated toothpaste	☐	☐

Medical History- Do you have or have you had any of the following medical conditions? * indicates premedication before treatment may be necessary!

	Yes	No		Yes	No
Heart Attack	☐	☐	Heart Surgery	☐	☐
Mitral Valve Prolapse *	☐	☐	Heart Disease	☐	☐
Artifical Heart Valve *	☐	☐	Heart Murmur *	☐	☐
Artificial Hip, Knee or Other *	☐	☐	Asthma	☐	☐
Rheumatic Fever *	☐	☐	Shortness of Breath	☐	☐
Transplant- Type *	☐	☐	Difficulty Breathng While Laying Down	☐	☐
Angina/Chest Pain	☐	☐	Diabetes- Type I or Type II	☐	☐
Pacemaker	☐	☐	Family History of Diabetes	☐	☐

	Yes	No		Yes	No
High/Low Blood Pressure	☐	☐	Persistent Cough	☐	☐
Swollen Ankles	☐	☐	Thyroid condition- Hypothyroid	☐	☐
History of taking Fen-Phen	☐	☐	Hepatitis- Type	☐	☐
Cancer History- Type	☐	☐	Liver Disease	☐	☐
Radiation Therapy	☐	☐	Jaundice	☐	☐
Chemotherapy	☐	☐	HIV Postitive, ARC, AIDS	☐	☐
Tuberculosis	☐	☐	Herpetic Outbreaks/Cold Sores	☐	☐
Emphysema	☐	☐	Arthritis	☐	☐
Kidney Disorder	☐	☐	Bleeding Disorder	☐	☐
Stomach Ulcers	☐	☐	Sickle Cell Disease	☐	☐
Stroke	☐	☐	Alcoholism	☐	☐
Blood Transfusion	☐	☐	Drug Addiction	☐	☐
Bruise Easily	☐	☐	Psychiatric Treatment	☐	☐
Fainting or Dizziness	☐	☐	Post Traumatic Stress Disorder (PTSD)	☐	☐
Epilepsy or Seizures	☐	☐	Osteoporosis	☐	☐
Glaucoma	☐	☐	Seasonal Allergies	☐	☐
Steroids or Prednisone in last 2 years	☐	☐	Sinus Problems	☐	☐

Women only. Are you pregnant, thinking you might be pregnant or trying to get pregnant? _____
Are you taking birth control? Yes/No Are you aware that antibiotics may interfere with the birth control pill? Yes/No

List all medications that you currently take, including over the counter supplements. As well as doses.

Any other information of importance not previously reported?

_____

_____

I hereby grant perimission to the staff of this office to administer such medications and anesthetics deemed necessary, and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also grant permission to share information about myself to my referring dentist, my physician, and my insurance company. The medical and dental information I have provided is correct to the best of my knowledge. I will notify this office about any changes in my medical or dental health. Please advise us of any objections to these instructions.

Patient Signature: _____ Date: _____

Dentist's Signature: _____

Health History Reviewed:

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____