POCATELLO Periodontics
PERIODONTAL & IMPLANT SERVICES

HEALTH QUESTIONNARE FORM

Circle One

..... What is your estimation of your general health? GOOD – FAIR – POOR

Yes No Are you now under the regular care of a physician?
If so, for what? _____
When was your last physical examination? _____

Yes No Have you had any major operations, hospitalization or illnesses?
If so, for what? _____

Yes No Are you taking any pills, medication or drugs?
If so, please list. _____

Yes No Have you had any unusual reaction or allergies to any medications or foods?
If so, please list. _____

..... Have you ever had a reaction to any of the following: (PLEASE CHECK)

____ Penicillin
____ Sulfa drugs
____ Codeine
____ Aspirin
____ Bisphosphonates
____ Sleeping pills (Barbiturates)
____ Tetracycline
____ Dental anesthetic (Novocaine)
____ Nitrous Oxide (Laughing Gas)

Yes No Do you smoke?

Yes No Do you drink alcohol?

Yes No Are you on a diet of any kind?

Yes No Has any member or your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer? If yes, who? _____

..... Do you have or have you ever had: (PLEASE CHECK)

____ Rheumatic fever
____ Heart murmur
____ Heart attack
____ Arteriosclerosis
____ Diabetes
____ Stroke
____ Abnormal thirst
____ Tumors or growths
____ X-ray or radiation therapy
____ Problems in healing
____ Frequent headaches
____ Allergies
____ Glaucoma
____ Frequent fractures or dislocations
____ Condition requiring cortisone or other steroids
____ Hepatitis, jaundice or other liver disease
____ Shortness of breath or chest pains upon exertion
____ Tuberculosis, emphysema or other lung disease
____ Epilepsy, seizures, convulsions or fainting spells
____ Swelling of the hands, feet or eyes
____ Painful or frequent urination
____ Ulcers (stomach or duodenal)
____ Kidney or bladder trouble
____ High or low blood pressure
____ Thyroid or parathyroid disease
____ Asthma or difficulty breathing
____ Anemia or other blood disorder
____ Frequent vomiting or diarrhea
____ Arthritis or rheumatism
____ Painful or swollen joints
____ Rashes or skin disorders
____ Dizziness or light headaches
____ Sinus problems
____ Sexually related disease

Yes No Are you excessively nervous or depressed?

Yes No Have you ever been treated for nervous or metal disorders?

Yes No Do you find it necessary to sleep using two pillows?

Yes No Have you recently gained or lost excessive amounts of weight?

Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

WOMEN ONLY:

Yes No Are you pregnant?
Yes No Are you taking birth control pills?
Yes No Do you have menstrual problems?
Yes No Have you reached menopause (Change of Life)?

DENTAL HEALTH

Yes No Do you consider yourself in good dental health?
Yes No 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?
Have you ever had:
____ Orthodontic treatment (Braces)
____ Oral Surgery (Extraction, etc.)
____ Periodontal treatment
____ Your teeth ground or bite adjusted
____ A bite plate or other appliance
Yes No Have you noticed any loosening of your teeth?
Yes No Does food tend to become 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 any unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth?
Reasons: Decay ( ) Gum Disease ( ) Other ( )
Yes No Have missing teeth been replaced?
Yes No Do you ever had any soreness, pain, clicking or popping in the area in front of your ears?
Do you:
____ Clench or grind your teeth while awake or asleep
____ Bite your lips or cheeks regularly?
____ Hold foreign objects with your teeth?
____ Breath primarily through your mouth?

When did you last have your teeth cleaned before this appointment? _____
How long before that? _____
How often do you see your dentist? _____
How often and when do you brush your teeth? _____
Do you use: Hand tooth brush ( ) Electric toothbrush ( )
Is your toothbrush: Soft ( ) Medium ( ) Hard ( )
What else do you use to clean your teeth? (floss, toothpick, waterpick, etc.) _____
How often? _____
Yes No Do you feel apprehensive when you are having a dental treatment?
Yes No Would you like to use nitrous oxide (laughing gas)?
Yes No Does the fear of pain make you postpone your dental treatment?
Yes No Is it important to you to keep your teeth?
Yes No Would you spend fifteen minute a day in order to keep your natural teeth?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor.

Signature _____ Date _____