GRAY'S PERIODONTAL CENTER

Andrew K. Gray, PharmD, DDS, MDS

HEALTH HISTORY QUESTIONNAIRE

DATE: ______________________ Patient Name: ______________________

Birth Date: ______________________

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, circle its number or letter. This Health History Questionnaire will become a part of the patient's dental record and will be considered confidential information.

Name of Your Physician: ______________________ Office Telephone: ______________________

Address of Your Physician ______________________

1. Are you in good health? .... Yes No Don't Know
2. Has there been any change in your health in the last year? .... Yes No Don't Know
   If yes, explain: ______________________
3. Have you ever been hospitalized, had a major operation or serious illness? .... Yes No Don't Know
   If yes, explain: ______________________
4. Date of your last visit to the doctor: ______________ Reason for last visit: ______________
5. Are you currently receiving treatment or regular medical care by your doctor? .... Yes No Don't Know
   If yes, for what condition(s)? ______________________
   ____
6. Are you taking any of the following medications:
   a. Antibiotics or sulfa drugs .... Yes No Don't Know
   b. Anticoagulant (blood thinners) .... Yes No Don't Know
   c. Medication for high blood pressure .... Yes No Don't Know
   d. Cortisone (steroids) .... Yes No Don't Know
   e. Tranquilizers .... Yes No Don't Know
   f. Antihistamines .... Yes No Don't Know
   g. Aspirin .... Yes No Don't Know
   h. Insulin, tolbutamide (Orinase) or other drugs for diabetes .... Yes No Don't Know
   i. Digitalis, Nitroglycerin or other drugs for heart trouble .... Yes No Don't Know
   j. Birth control pills or other hormones .... Yes No Don't Know
   k. Pain medications such as Advil, Nuprin, Motrin, or Naprosyn .... Yes No Don't Know
   l. Synthroid or other thyroid medication .... Yes No Don't Know
   m. AZT or other drugs for HIV .... Yes No Don't Know
   n. Others, please list: ______________________
7. Have you ever taken fen-phen (fenfluramine/phentermine combination)? .... Yes No Don't Know
8. Have you had any allergic or unusual reactions to any substance or medication? .... Yes No Don't Know
   If yes, specify what substance/medications, and what reactions ______________________

HAVE YOU EVER BEEN TREATED BY A DOCTOR FOR *(Circle your response and underline any condition(s))*

9. Damaged heart valves, artificial heart valves, heart murmur rheumatic fever, rheumatic heart disease .... Yes No Don't Know

10. Congenital heart problems .... Yes No Don't Know
11. Heart trouble, heart attack, high blood pressure, stroke? .... Yes No Don't Know
12. Do you have pain in your chest upon exertion? .... Yes No Don't Know
13. Blood disorders such as anemia or hemophilia .... Yes No Don't Know
14. Breathing problems, emphysema, tuberculosis or other lung problems? .... Yes No Don't Know
15. Asthma, hay fever or hives? .... Yes No Don't Know
16. Stomach or intestinal ulcers? .... Yes No Don't Know
17. Cancer, x-ray treatments, or chemotherapy? .... Yes No Don't Know
18. Thyroid trouble? .... Yes No Don't Know
19. Diabetes or blood sugar problems? .... Yes No Don't Know
20. Hepatitis, jaundice, or liver disease? .... Yes No Don't Know
21. Kidney infections, frequent urination, or renal (kidney) dialysis? .... Yes No Don't Know
22. Stroke, seizure, fainting spells, numbness or other neurological problems? .... Yes No Don't Know
23. Syphilis, gonorrhea, or genital herpes, sexually transmitted disease? .... Yes No Don't Know
24. AIDS, AIDS-related condition or HIV positive? .... Yes No Don't Know
25. Tumors, or growth? .... Yes No Don't Know
26. Arthritis or rheumatism? .... Yes No Don't Know
27. Phobias, anxieties, depression, psychoses, fears, other mental problems? .... Yes No Don't Know
28. For women, are you pregnant or do you think you may be pregnant? .... Yes No Don't Know
29. Have you lost weight without dieting or gained weight in recent months? .... Yes No Don't Know
30. Are there any other problems about your health that you know of? .... Yes No Don't Know
    If yes, describe: ____________________

HABITS AND PERSONAL HISTORY:

31. Do you now or have you ever used recreational drugs (besides alcohol or tobacco)? Yes No
32. How many packs cigarettes do you smoke per day? How many years? _______ Packs/Day _______ #Yr s_______
    a. If you smoked in the past how many packs per day did you smoke? How many years?___Packs/Day___#Yrs___
    b. If you smoke, are you interested in help quitting? .... Yes No
33. How many drinks of beer, wine or liquor do you have per day? ____________________ Drinks per Day

34. How often do you have your teeth cleaned/dental check-ups? ____________________
35. What do you do each day to take care of your teeth and gums? ____________________
36. Have you ever had any specialized dental treatment .... Yes No Don't Know
37. Have you ever had an unusual reaction to a dental procedure or anesthetic? .... Yes No Don't Know
38. Have you ever experienced bleeding/complications following dental treatment? ... Yes No Don't Know
39. Have you had any injury to your teeth, jaws or face? .... Yes No Don't Know

CURRENT DENTAL CONCERNS:

40. What is your major dental concern? ____________________
41. Are you unhappy with the appearance of your teeth? .... Yes No Don't Know
42. Do your gums bleed when you brush your teeth or when you eat .... Yes No Don't Know
43. Do you clench or grind your teeth? .... Yes No Don't Know
44. Does food or dental floss cath between your teeth? .... Yes No Don't Know
45. Are some of your teeth becoming loose? .... Yes No Don't Know
46. Are there spaces between your teeth now where there were none before? .... Yes No Don't Know
47. Are your teeth sensitive to hot, cold, or pressure? .... Yes No Don't Know
48. Do any of your teeth ache? .... Yes No Don't Know
49. Do you experience pain or clicking in your jaw joints? .... Yes No Don't Know
50. Are there any sores or growths in your mouth? .... Yes No Don't Know
51. Are you worried about receiving dental treatment? .... Yes No Don't Know

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from any physician or dentist, any additional information regarding my medical history needed to provide me to the best dental treatment possible.

PERSON COMPLETING FORM:

Signature: ______________________________ Date: ______________________________

If other than patient, indicate relationship: ______________________________

Do not write below

MEDICAL HISTORY REVIEW

ATTENDING DENTIST: ______________________________ **PharmD, DDS**

Signature: ______________________________ Date: ______________________________

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