miami implant perio

**Health Questionnaire** **DATE:**

Name First Middle Last | Gender (Sex) | Birth date | AGE | Social Security No.

Address (Street, City, State, Zip Code)

Mobile Phone | Home/work Phone | Marital Status | Email address | Your Occupation

General Dentist's Name | Who Referred you ?

Person Responsible for Payment of Account | Relation | Phone

Address (Street, City, State, Zip Code)

**Dental Benefits Information**

**Primary Benefits**

Name & Address | Subscriber Social Security No.

Subscriber's Name | Group or Company Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc)

**SecondaryBenefits**

Name & Address | Subscriber Social Security No.

Subscriber's Name | Group or Company Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc)

miami implant perio

**General Health** **Name:** _____

The following information will make it possible for us to be more successful and through in your treatment. Your answers are for our records only and will be considered confidential.

**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 reason?_____

**Physician's Name**:_____

When was your last physical examination?_____

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

Yes No **Are you taking any pills, prescription medications 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 had an abnormal reaction to any of the following? **PLEASE CHECK**

___Penicillin
___Sulfa drugs
___Codeine
___Aspirin
___Bisphosphonates
___Sleeping pills (Barbiturates)
___Tetracycline
___Dental anesthesia (Novocain)
___Nitrous Oxide (Laughing gas)
___Other _____

Yes No **Do you smoke?**
If so, how much and for how many years? _____
If so, how interested are you in quitting? VERY / SOMEWHAT / NOT INTERESTED

Yes No Do you drink alcohol?

Yes No Are you on a diet of any kind?

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

Yes No Do you consider yourself a nervous or depressed person?

Do you have or have you ever had any of the following? **PLEASE CHECK OR CIRCLE**

___Rheumatic fever
___Heart murmur, mitral valve prolapse
___Heart attack
___Arteriosclerosis
___Diabetes Type I or II
___Stroke
___Abnormal thirst
___Tumors, growths, cancer
___X-ray or radiation therapy
___Problems with healing
___Frequent headaches
___Congenital heart disease
___Glaucoma
___Frequent fractures or dislocations
___Cortisone or steroid therapy
___Hepatitis, jaundice or other liver disease
___Shortness of breath/chest pain upon exertion
___Tuberculosis, emphysema or other lung disease
___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 headedness
___Sinus problems
___Sexually-transmitted infections, HIV
___Artificial heart valve
___Previous infective endocartitis
___Autoimmune disease
___Osteoporosis
___ Other _____

**Women Only:**

**Circle one**

Yes No Are you pregnant?
Yes No Are you taking birth control pills?
Yes No Do you have menstrual problems?
If so, please explain: _____
Yes No Have you reached menopause?

**Dental Health**

Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your general health in any way?
Yes No Are you satisfied with the appearance of your teeth?
Yes No Are you satisfied with your chewing ability?
Have you had any of the following: PLEASE CHECK
___Orthodontic treatment (braces)
___Oral surgery (tooth extractions/removal)
___Periodontal treatment (gum surgery)
___Your bite adjusted or teeth ground
___A bite plate or night guard 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 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?
If so, what was the cause for removal? ___Decay ___Gum disease ___Other
Yes No Have missing teeth been replaced?
Yes No Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?
Do you do any of the following: PLEASE CHECK
___Clench or grind your teeth while awake or asleep
___Bite your lips or cheeks regularly
___Hold foreign objects in your mouth
___Breathe primarily through your mouth
When did you last have your teeth cleaned professionally prior to this appointment? _____
How often do you see your dentist? _____
How often and when do you brush your teeth? _____
What kind of toothbrush do you use? ___manual ___ electric
What type of bristles does your brush have? ___soft ___medium ___hard
Do you use any other oral hygiene aids daily? If so, please describe: _____
Yes No Do you feel apprehensive about dental treatment?

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Terry and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Terry, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____ _____
Signature of patient or Legal Guardian Signature of Doctor Date

For Completion by Doctor

Comments: _____