Medical / Dental History Form

Kelsey Periodontal Group

Patient Name: _____ Date of Birth: _____

Do you have or have you had any of the following?

Artificial / Prosthetic Heart Valve	No	Yes
History of Infective Endocarditis	No	Yes
Congenital Heart Disease / Defects	No	Yes
Heart Disease / Heart Attack	No	Yes
Pacemaker / Implanted Defibrillator	No	Yes
High Blood Pressure	No	Yes
Chest Pains or Angina	No	Yes
Stroke / Transient Ischemic Attacks (TIAs)	No	Yes
Artificial Joint(s)	No	Yes
Hepatitis / Liver Disease	No	Yes
Tuberculosis (TB)	No	Yes
Kidney Disease	No	Yes
Diabetes or Pre-Diabetes	No	Yes
Implanted Cochlear (Ear) Device	No	Yes
Asthma	No	Yes
HIV	No	Yes
Arthritis (Osteoarthritis or Rheumatoid)	No	Yes
Osteoporosis / Osteopenia	No	Yes
Radiation or Cancer Chemotherapy	No	Yes
Known Autoimmune Conditions / Disease	● No	● Yes

Do you have, or have you had any disease, condition or problem not listed here? If so, fill out field below:

When was the last time you were hospitalized?

Have you had excessive or prolonged bleeding requiring special treatment? No Yes

Do you have any known allergies? Please list each one No Yes

Do you currently smoke tobacco? No Yes

Have you ever smoked tobacco? No Yes

Do you smoke non-tobacco products? No Yes

How much do you smoke daily?

Do you use smokeless tobacco? No Yes

Have you ever used smokeless tobacco? No Yes

How frequently do you use it?

Are you currently under the care of a physician(s)? No Yes

When were you last seen by a physician?

Name of Physician: Phone Number:

Street Address:

Which pharmacy do you wish any prescriptions called in to?
Pharmacy Location (and phone number if possible)

Are you pregnant? No Yes When is the estimated due date?

Are you nursing? No Yes

Periodontal Gum Health Questionnaire

1) What is your chief concern, the reason for your visit to the periodontist?

2) Prior to your most recent visit, please estimate the last time you visited the dentist.

3) Prior to your most recent visit, please estimate the last time you had your teeth cleaned.

4) Do you know anyone in your family who has been diagnosed with periodontal (gum) disease? No Yes

5) Have you ever been treated for periodontal disease in the past? No Yes

(a) Do you remember what treatment you had? If so, please describe.

(b) How long ago did you receive this/these treatment(s)?

6) Have you ever had a dental implant placed? No Yes

Do you have multiple implants? No Yes

7) If so, how long ago were your dental implants placed?

8) Have you ever had any problems with dental treatment in the past? If so please describe.

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Do you have any other concerns you wish to speak about?

List of Current Medications

Drug Name, Dose/Frequency, Reasons for Taking

Please sign below to attest that the information provided is complete and correct.

Signature

Date

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