SOUTH CALGARY PERIODONTAL GROUP

Specialists in Periodontics and Dental Implants

PERIODONTISTS

HEALTH HISTORY

Mr/Mrs/Miss/Ms. ______________________ Date of Birth ______ (DAY MONTH YEAR)

Home Address ______________________ Postal Code ______

______________________ Telephone ______

Patient's Occupation ______________________ Telephone ______

Whom may we thank for referring you to our office? ______________________

Do you have Dental Insurance? **INSURANCE INFORMATION**

Policy Holder Name: ______________________ Date of Birth ______ (DAY MONTH YEAR)

Employer: ______________________ Telephone # ______

Insurance Carrier: ______ Policy #: ______ Div.: ______ Cert #: ______

Dual Plan

Policy Holder Name: ______________________ Date of Birth ______ (DAY MONTH YEAR)

Employer: ______________________ Telephone # ______

Insurance Carrier: ______ Policy #: ______ Div.: ______ Cert #: ______

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Periodontal disease may be caused by a combination of several factors and the following questions are designed to help us identify them. The success of therapy is dependent upon this. Therefore, although some of the following questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health and are confidential.

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CIRCLE ONE
*DK - Don't Know

1. Who is your family physician? ______________________
2. Are you taking blood thinners? ______ Yes No DK
3. Are you taking or have you taken any drugs within the past year? ______ Yes No DK
   (example: tranquilizers, steroids, aspirin) List: ______________________
4. Have you had heart surgery or joint replacement? ______ Yes No DK
5. Do you have or have you ever had any of the following conditions:

Condition				Condition			
Asthma	Yes	No	DK	Diabetes	Yes	No	DK
Rheumatic Fever	Yes	No	DK	Jaundice	Yes	No	DK
Heart problems - Angina	Yes	No	DK	Hepatitis (liver disease)	Yes	No	DK
High blood pressure	Yes	No	DK	Thyroid or Parathyroid disorder	Yes	No	DK
Stroke	Yes	No	DK	Kidney problems	Yes	No	DK
Abnormal blood count	Yes	No	DK	Arthritis or Rheumatism	Yes	No	DK
Tumor or growth	Yes	No	DK	Tuberculosis	Yes	No	DK
Radiation or Chemotherapy	Yes	No	DK	Emphysema	Yes	No	DK
Lupus	Yes	No	DK	Herpes	Yes	No	DK
Epilepsy	Yes	No	DK	Glaucoma	Yes	No	DK
Cancer	Yes	No	DK	H.I.V.	Yes	No	DK

6. Has your general health changed in the past year? ______ Yes No DK
7. Have you ever had any serious illnesses or major operations? ______ Yes No DK

____

(Con't)

8. Have you had abnormal bleeding associated with previous tooth extraction, surgery, or trauma? Yes No DK

9. Have you ever had any allergies (food, dust, drugs, fur, latex, etc.)? Yes No DK

10. Are you allergic or have you had an adverse reaction to any of the following:

Dental anaesthetics (novocaine, etc.)	Yes	No	DK	Aspirin	Yes	No	DK
Penicillin or other antibiotics	Yes	No	DK	Codeine	Yes	No	DK
Barbiturates (sleeping pills)	Yes	No	DK	Other drugs	Yes	No	DK

11. Do you consider yourself a nervous person? Yes No DK

12. Do you smoke or have you ever smoked or used other tobacco products? Yes No DK

13. If yes, how long? ______ Date quit? ______

DENTAL HISTORY

14. What is your reason for coming to this office? ______

15. Have you had any swollen, bleeding or receeding gums? Yes No DK

16. Have you noticed bad mouth odors or tastes? Yes No DK

17. Have you, in the past, ever had periodontal (gum) teatments? When and by whom? ______ Yes No DK

______ Yes No DK

18. When did you last have your teeth cleaned? ______

19. Have you noticed any loose teeth? Yes No DK

20. Would you be willing to spend several minutes per day cleaning your teeth? Yes No DK

21. Are you satisfied with the appearance of your teeth? Yes No DK

22. Have you ever had orthodontic treatment (braces)? Yes No DK

23. Do you breathe primarily through your mouth? Yes No DK

24. Do you have a dry mouth? Yes No DK

FOR WOMEN ONLY

25. Are you pregnant at the present time? ______ Expected due date ______

26. Note: Certain medicaitons (e.g. antibiotics) may inhibit the effectiveness of oral contraceptives.

I hereby give consent to have a periodontal (dental) examination and or relief of pain treatment. This treatment may include use of various medications such as: local anaesthetics (freezing), antibiotics, analgesics (pain killers), and others as required.

DATE: ______ SIGNED ______

Parent or Guardian if Under Legal Age