Periodontal Associates, P.A.
Architects of Health
Practice Limited to Periodontics and Implants

Stephen G. Morse, D.M.D.
Michael T. Cwiklinski, D.M.D.

Health Questionnaire

Name _____ Date _____ Sex M / F

Street _____ City _____ State _____ Zip _____

Date of Birth: _____

Home # _____ Cell # _____ Work # _____

Email _____ Use (circle one) Home/Work/Cell/Email for appointment reminders

Reason for today's appointment ? _____

In an emergency, whom should we contact? _____ Phone _____

Medical History

Are you currently under the care of a physician? Yes / No Who? _____

Primary Physician _____ Phone _____

Last physical exam? _____ Height _____ Weight _____

Do you take aspirin daily? Yes / No Dose _____ Was this physician prescribed? Yes / No Who? _____

Do you see a cardiologist Yes / No Name_____

Do you have an artificial joint? Yes / No Surgeon _____

Do you smoke or chew tobacco products? Yes / No How much? _____ How long? _____

Do you drink alcohol? Yes / No How much? _____ How often? _____

Do you consider yourself to be in good health? Yes / No

Allergies - Do you have an allergy or adverse reaction to: (please circle yes or no to each, use extra space to elaborate)

Penicillin/Antibiotics	Yes / No	Latex	Yes / No
Codeine/Oxycodone	Yes / No	Aspirin	Yes / No
Motrin/Ibuprofen	Yes / No	Food	Yes / No _____
Local Anesthesia	Yes / No	Medications	Yes / No _____
Novocaine/Lidocaine	Yes / No	Other	Yes / No _____

Do you have or have you had any of the following? (Please circle yes or no to each)

AIDS/HIV	Yes / No	COPD	Yes / No	Pacemaker	Yes / No
Allergies	Yes / No	Diabetes	Yes / No	Prosthetic Heart Valve	Yes / No
Angina	Yes / No	Fainting Spells	Yes / No	Radiation Treatment	Yes / No
Artificial Joint(s)	Yes / No	Glaucoma	Yes / No	Respiratory Disease	Yes / No
Arthritis	Yes / No	Heart Attack	Yes / No	Rheumatoid Arthritis	Yes / No
Asthma	Yes / No	Heart Disease	Yes / No	Rheumatic Heart Disease	Yes / No
Auto Immune Disease	Yes / No	Recent Heart Stent	Yes / No	Rheumatic Fever	Yes / No
Bacterial Endocarditis	Yes / No	Heart Transplant	Yes / No	Seizures	Yes / No
Bleeding Problems	Yes / No	Hepatitis (Type: _____)	Yes / No	Sexually transmitted disease	Yes / No
Blood Disease	Yes / No	High/Low Blood Pressure	Yes / No	Sinus problems	Yes / No
Bruise Easily	Yes / No	Hives/Skin Rash	Yes / No	Stomach/Intestinal ulcers	Yes / No
Cancer	Yes / No	Kidney Disease	Yes / No	Stroke	Yes / No
Circulatory Problems	Yes / No	Liver Disease	Yes / No	Thyroid Disease	Yes / No
Congenital Heart Defect	Yes / No	Nervous Disorder	Yes / No	Tuberculosis	Yes / No
Congestive Heart Failure	Yes / No	Osteoporosis/Osteopenia	Yes / No	Weight changes	Yes / No

Women: Are you pregnant Yes / No OB _____ Phone _____ Due Date _____

Taking birth control pills? Yes / No

Do you take antibiotics prior to a dental appointment? Yes / No Who prescribed? _____

Why? _____

List all prescribed medications with dosages - indicate the prescriber if not primary physician
(antibiotics, anticoagulants, steroids, statins, insulin, tranquilizers, blood pressure medication, etc.) Use separate sheet, if preferred or needed.

List all over-the-counter medications/herbal supplements with dosages (vitamins, minerals, St. John's Wort, aspirin) Use separate sheet, if preferred or needed.

Describe any hospitalizations plus conditions, diseases or problems not listed on front? Yes / No (list) Use separate sheet, if preferred or needed.

Have you had any health changes in the past year? Yes / No (please describe) Use separate sheet, if preferred or needed.

Dental History

Dentist _____ Phone _____ Date of last dental visit _____

When was your last dental cleaning?_____ Frequency _____

How often do you brush? _____ Floss? _____ Other? _____

Are you having any discomfort/pain?	Yes / No	Do you have pain in jaw or in front of ear?	Yes / No
Are your teeth sensitive to hot/cold?	Yes / No	Do you have a bad taste or odor?	Yes / No
Are your teeth sensitive to biting/chewing?	Yes / No	Do you breathe through your mouth?	Yes / No
Do your gums bleed?	Yes / No	Are you nervous about dental treatment?	Yes / No
Do you clench/grind teeth?	Yes / No	Are you under significant stress?	Yes / No
Does you jaw "click"?	Yes / No	Are you happy with appearance of teeth?	Yes / No

Have you had orthodontic treatment (braces?) Yes / No When/Where? _____

Have you had previous periodontal treatment? Yes / No When/Where? _____

Personal

How did you hear about our office? _____

Marital status? _____ Health of partner? Good Fair Poor

Number and ages of children _____

Occupation _____

Rate your personal satisfaction with your occupation : Good Fair Poor

Signature _____ ***Date*** _____

Office Use Only: BP _____ *Pulse* _____ *Initials* _____ *Date* _____