ARIZONA PERIODONTICS

HEALTH HISTORY

NAME: DATE:	
PHYSICIAN: OFFICE PHONE:	
APPROXIMATE DATE OF LAST PHYSICAL EXAMINATION?	
ARE YOU UNDER MEDICAL TREATMENTS NOW?	YES NO
HAVE YOU HAD ANY MAJOR OPERATIONS IN THE LAST YEAR?	YES NO
IF SO WHAT?	
DO YOU HAVE ANY DRUG ALLERGIES, INCLUDING PENICILLIN?	YES NO
HAS A PHYSICIAN EVER INFORMED YOU THAT YOU HAD:	YES NO
A HEART AILMENT?	YES NO
HIGH BLOOD PRESSURE?	YES NO
RESPIRATORY DISEASE?	YES NO
DIABETES?	YES NO
RHEUMATIC FEVER?	YES NO
RHEUMATISM OR ARTHRITIS?	YES NO
TUMORS OR GROWTHS?	YES NO
ANY BLOOD DISEASE OR HIV +?	YES NO
. ANY LIVER DISEASE?	YES NO
ANY KIDNEY DISEASE?	YES NO
ANY STOMACH OR INTESTINAL DISORDER?	YES NO
ANY BLEEDING OR CLOTTING DISORDER?	YES NO
. YELLOW JAUNDICE OR HEPATITIS?	YES NO
ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME?	YES NO
ARE YOU TAKING ANY MEDICATION, ASPIRIN, OR BIRTH CONTROL PILLS?	YES NO
IF SO WHAT?	
ARE YOU ALLERGIC TO ANY KNOWN MATERIALS RESULTING IN HIVES, ASTHMA?	YES NO
IF SO WHAT?	
HAVE ANY WOUNDS HEALED SLOWLY OR PRESENTED ANY OTHER COMPLICATIONS?	YES NO
WOMEN ARE YOU PREGNANT?	YES NO
DO YOU HAVE A HISTORY OF FAINTING?	YES NO
HAVE YOU EVER HAD ANY RADIATION TREATMENTS? IF SO, WHEN?	YES NO
DENTAL HISTORY	
DO YOU HAVE PAIN IN OR NEAR YOUR EARS?	YES NO
ANY UNHEALED INJURIES OR INFLAMED AREAS IN OR AROUND YOUR MOUTH?	YES NO
HAVE YOU EXPERIENCED ANY GROWTH 0R SORE SPOTS IN YOUR MOUTH?	YES NO
DO YOU HABITUALLY CLENCH YOUR TEETH DURING THE NIGHT OR DAY?	YES NO
DO YOU HAVE A HISTORY OF TEMPOROMANDIBULAR DISORDER (TMD)?	YES NO
HAVE YOU EVER HAD A LOCAL ANESTHETIC?	YES NO
ANY REACTIONS OR ALLERGIC SYMPTOMS TO LOCAL ANESTHETIC?	YES NO
PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	YES NO
DO YOUR GUMS BLEED?	YES NO
HAVE YOU HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH AND GUMS?	YES NO
DO YOU HAVE ANY DENTAL COMPLAINTS AT THE PRESENT TIME?	YES NO
WHEN WAS YOUR LAST SET OF FULL MOUTH X-RAYS TAKEN? WHERE?	YES NO
DO YOU HAVE A GENERAL DENTIST?	YES NO
NAME OF GENERAL DENTIST :	
PATIENT SIGNATURE DATE:	