MPDG

MARIN PERIODONTICS
DENTAL GROUP

Dental Implants ■ Periodontal Microsurgery ■ Cosmetic Periodontics ■ Supportive Perio Therapy ■ Oral Medicine ■ Reconstructive Periodontics

Health Questionnaire

Patient's Name _____

General Physician _____ Your HMO I.D. #_____

Dr. Address _____ City _____ Phone _____

Your Age _____ Height _____ Weight _____ Mo/Year of your last medical examination _____

How would you describe your present health (circle one): excellent good fair poor don't know

YES NO ???

❒ ❒ ❒ Has there been any change in your general health in the past year?

❒ ❒ ❒ Have you had a serious illness, operation or hospitalization during the past five years?

If yes, please describe _____

❒ ❒ ❒ Are you taking or have you recently taken any of the following:

Prescription medications: _____

Over the counter, natural or herbal preparations: _____

❒ ❒ ❒ Aspirin? Dosage_____ Coumadin? (protime) _____

❒ ❒ ❒ Have you ever taken Pondimin (fendluramine), Phen-Fen (phentermine) or Redux (dexphenfluramine) for weight reduction?

❒ ❒ ❒ Has your M.D. told you to take antibiotics prior to having any type of dental procedure? Rx? _____

❒ ❒ ❒ Are you allergic to any medications or drugs, latex, iodine? _____

❒ ❒ ❒ Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (motrin)?

❒ ❒ ❒ Have you ever had excessive bleeding that required special treatment?

❒ ❒ ❒ Have you been diagnosed as having any Immuniodeficiency, ARC or AIDS?

❒ ❒ ❒ Are you taking any medication for osteoporosis or osteopenia? Rx? _____

❒ ❒ ❒ Is there a history of diabetes in your family?

❒ ❒ ❒ Are you required, due to health, to restrict your work or activity in any way?

❒ ❒ ❒ Are you on a special or restricted diet of any kind?_____

❒ ❒ ❒ Do you use any kind of tobacco? If so how much: _____ per day, week, month

❒ ❒ ❒ Do you use any kind of alcohol? If so how much: _____ per day, week, month

❒ ❒ ❒ Do you have any history of substance abuse or do you currently use recreational drugs?

For women, check all that are appropriate: ❒ I am pregnant ❒ I am nursing ❒ I am taking birth control pills

Check all of the following that you may have had in the past or that currently apply to you:

- ❒ chest pain upon exertion
- ❒ shortness of breath
- ❒ high blood pressure
- ❒ low blood pressure
- ❒ heart valve prosthesis
- ❒ mitral valve prolapse
- ❒ congenital heart lesion
- ❒ rheumatic fever
- ❒ heart murmur
- ❒ damaged heart valve
- ❒ heart arrhythmia
- ❒ tachycardia
- ❒ heart surgery
- ❒ cardiac pacemaker
- ❒ hepatitis ❒ A ❒ B ❒ C
- ❒ jaundice
- ❒ received blood transfusion
- ❒ impaired liver function
- ❒ kidney disease
- ❒ impaired kidney function
- ❒ esophygeal reflux
- ❒ hiatal hernia
- ❒ G.I. ulcers
- ❒ anorexia or bulimia
- ❒ eating disorder
- ❒ diabetes
- ❒ radiation therapy
- ❒ chemotherapy
- ❒ history of cancer
- ❒ asthma
- ❒ bronchitis
- ❒ emphysema
- ❒ sinus troubles
- ❒ persistent cough
- ❒ tuberculosis
- ❒ joint replacement surgery
- ❒ arthritis
- ❒ connective tissue disorder
- ❒ neurological disorders
- ❒ stroke
- ❒ headaches
- ❒ migraines
- ❒ epilepsy
- ❒ seizures
- ❒ mental health problems
- ❒ glaucoma
- ❒ wear contact lenses
- ❒ severely impaired vision
- ❒ recurrent infections
- ❒ chronic fatigue
- ❒ recent weight loss

Do you have any disease, problem or condition not listed above? Please explain: _____

Signature of patient or legal guardian _____ Date _____ Reviewed by _____

01/12

(Over)

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Dental Questionnaire

Your Dentist's Name _____ for how long:_____

How frequently have you had your teeth cleaned during the past 5 years:

☐Less than once a year ☐Once a year ☐Twice a year ☐Three times a year ☐Four times a year

Mo/Year of your last dental exam_____ Mo/Year of your last dental x-rays_____

Are you presently satisfied with the condition of your mouth and teeth(circle one):

☐Very satisfied ☐Satisfied ☐It's o.k. ☐Somewhat dissatisfied ☐Very dissatisfied

YES	NO	
☐	☐	Do you presently have any pain, discomfort or impaired function related to your mouth? If yes, please describe? _____
☐	☐	Are you currently aware of any infection in your mouth? If yes, please describe: _____
☐	☐	Are you currently taking any antibioitics for infection? If so, what: _____
☐	☐	Do your gums ever bleed? If so, when:_____
☐	☐	Do you have a problem with bad breath or have any friends or family made you aware of this?
☐	☐	Are you interested in replacing lost teeth?
☐	☐	Do you ever have aches or pains in your jaw joints, ears, face, neck or head?
☐	☐	Are any of your teeth tender when you chew hard foods?
☐	☐	Are any of your teeth more sensitive to: cold, hot, sweets, certain foods or drinks?
☐	☐	Are any particular teeth very sensitive or painful? when?_____
☐	☐	Are you concerned about gum recession around any of your teeth?
☐	☐	Are you concerned about the appearance of your teeth or mouth?
☐	☐	Have you ever had Orthodontic treatment? ☐With braces ☐With removable appliances When did you go through Orthodontic care? _____
☐	☐	Have you ever received Periodontal treatment? ☐Scaling/root planing ☐Gum surgery When did you go through Periodontal care? _____

Check any of the following that describe you or makes dental treatment easier for you:

- ☐ I tolerate most dental care reasonably well and usually require minimal use of anesthesia
- ☐ I aprpeciate the use of local anesthetic – it allows me to tolerate most dental care reasonably well
- ☐ I tolerate shots in my mouth when they are given well
- ☐ I like the benefits of nitrous oxide (laughing gas)
- ☐ I prefer to be sedated for any surgical treatment
- ☐ I prefer to be sedated for any lengthy surgical care
- ☐ I have a hard time sitting in the dental chair for more than an hour
- ☐ I have a hard time sitting in the dental chair very long due to a neck, back, spine problem
- ☐ I have difficulty when tilted back in the dental chair (dizziness, breathing difficulty, _____

What are your goals or priorities for the health, function and appearance of your teeth & mouth:
(rate each item from 1 to 5 with 1 being your lowest priority and 5 your highest – you can use the same number more than once)

____be able to chew food and eat what I enjoy
____preserve my teeth & avoid dentures
____be free of infection
____be free of mouth pain & tenderness
____avoid removable bridgework
____for my mouth to look nice when I smile
____make my teeth look good
____have a healthy and hassle-free mouth

Signature of patient or legal guardian _____ Date _____ Reviewed by _____