Donna L. Massoth DDS, MSD, PhD, PLLC
Periodontics and Implant Dentistry

Patient Name: _____

Birthdate: _____ Today's Date: _____

Dental History

1 Current Dentist: _____ Phone _____ How Long? _____

2 Previous Dentist: _____ Phone _____ How Long? _____

3 What is your chief dental concern at this time? _____

4 How often are your teeth professionally cleaned? ____ /year Last cleaned? _____

5 Are your teeth sensitive to hot and cold? _____ yes / no

6 Have you had any complications with extractions? _____ yes / no

7 Do your gums bleed easily? _____ yes / no

8 Do you have any fears about dental treatment? _____ yes / no

9 Have you had any difficulty with dental anesthetic? _____ yes / no

10 Have you ever been treated for gum disease or gum recession? _____ yes / no

11 Are you aware of any lumps or swelling in your mouth? _____ yes / no

12 Do you grind or clench your teeth (day or night)? _____ yes / no

13 Are you satisfied with your teeth and gums? _____ yes / no

14 Do you have any breath concerns? yes / no

15 How often do you **brush** in a *day* ? _____ How often do you **floss** in a *week* ? _____

16 Do you **regularly** use any of the following? (circle) manual brush sonic brush (i.e. Sonicare) electric brush (i.e. Oral B/Braun)
Flouride rinse Toothpick/Stimudent Rubber tip Waterpik Interproximal brush Endtuft brush

Notes: _____

Medical History

1 Are you currently under the care of a physician? If yes, explain: _____

2 Doctor's Name: _____ Phone: _____

3 Have you ever had a serious illness or been hospitalized? _____

4 Any major changes in your health in the last year? _____

5 In case of an emergency, who should we contact? _____

6 Does your physician require you take antibiotics prior to dental treatment? If yes, explain: _____

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

Allergy Problems:	**Yes**	**No**
Enviromental or Chemical Sensitivity	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Skin Rashes	☐	☐

Bleeding Problems:	**Yes**	**No**
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Blood Transfusion	☐	☐
Easy Bruising	☐	☐

Bone, Joint, or Muscle Problems:	**Yes**	**No**
Arthritis	☐	☐
Back pain, Headache, or Neck pain	☐	☐
Fibromyalgia	☐	☐
Joint Replacement Hip, or Knee	☐	☐
Dates: _____		
Osteopenia, or Osteoporosis	☐	☐
Paget's disease	☐	☐

Cancer History:	**Yes**	**No**
Type:	☐	☐
Chemotherapy, or Radiation	☐	☐

Endocrine, Gastrointestinal & Skin Disorders:	**Yes**	**No**
Celiac Disease, or Gluten Intolerance	☐	☐
Crohns Disease	☐	☐
Diabetes: Insulin, Oral Meds, or Diet. A1C= ____	☐	☐
Kidney Condition: Dialysis, Shunt, or Other	☐	☐
Liver Cirrhosis, Jaundice, or Hepatitis	☐	☐
Lupus	☐	☐
MRSA	☐	☐
Poor Wound Healing	☐	☐
Sjogren's Syndrome	☐	☐
Thyroid Problem: Hypo / Hyper	☐	☐
Ulcers	☐	☐

Hearing & Vision Problems:	**Yes**	**No**
Impaired Vision	☐	☐
Glaucoma	☐	☐
Glasses or Contact Lens	☐	☐
Hearing Aid	☐	☐

Heart Problems:	**Yes**	**No**
Blocked Arteries (Atherosclerosis)	☐	☐
Blood Pressure Problem: High / Low	☐	☐
Chest Pain (Angina)	☐	☐
Irregular Heart Rhythm	☐	☐

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Heart Problems (continued):	Yes	No
Heart Attack (MI)	☐	☐
Heart Murmur	☐	☐
Heart Surgery: Bypass, Stent, or Valve	☐	☐
Pacemaker	☐	☐

Men Only:	Yes	No
Prostate problems	☐	☐
Erectile Dysfunction Meds	☐	☐

Psychological & Neurological Conditions:	Yes	No
Dementia or Alzheimer's	☐	☐
Head Injury	☐	☐
Multiple Sclerosis	☐	☐
Parkinson's Disease	☐	☐
Psychologic: Anxiety, Depression, or OCD	☐	☐
Seizures or Epilepsy	☐	☐
Stroke	☐	☐

Respiratory:	Yes	No
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Home Oxygen use	☐	☐
Pneumonia	☐	☐
Frequent Respiratory Infections	☐	☐
Shortness of breath	☐	☐
Sinus Trouble	☐	☐
Tuberculosis, Exposed to TB, Family Member with TB	☐	☐

Social Habits:	Yes	No
History of Alcohol or Drug Abuse	☐	☐
History of Smoking or Chewing Tobacco	☐	☐

If so, how much: _____

Quit? _____ When? _____

Viral:	Yes	No
Cold sores	☐	☐
Herpes or other STD	☐	☐
HIV positive	☐	☐
HIV AIDS	☐	☐
Other:	☐	☐

Women Only:	Yes	No
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Using Oral Contraceptives, or Other Hormone	☐	☐

In the past 12 months, have you taken any of the following? Blood Thinners:	Yes	No
Aspirin	☐	☐
Advil	☐	☐
Plavix	☐	☐
Coumadin	☐	☐
Lovenox	☐	☐
Warfarin	☐	☐

Have you ever taken any of the following? Osteoporosis Medication:	Yes	No
Fosomax	☐	☐
Actonel	☐	☐
Boniva	☐	☐
Reclast	☐	☐
Cancer Medication:		
Aredia	☐	☐
Zometa	☐	☐

Are you allergic, or have you reacted adversely to any of the following?

	Yes	No		Yes	No
Local Anesthetics ("Novocaine")	☐	☐	Penicillin, Erythromycin or Tetracycline	☐	☐
Epinephrine	☐	☐	Latex or Rubber dam	☐	☐
Aspirin, Acetaminophen, Ibuprofen	☐	☐	Reaction to Metals	☐	☐
Barbiturates, Sedatives, Sleeping Pills	☐	☐	Other	☐	☐
Codeine or other Narcotics	☐	☐			

Other: Do you have any disease, condition or problem not listed that you feel we should know about? If so, please describe:

_____

_____

_____

Medications: Please list any prescription, over-the-counter medications, vitamins, herbal remedies or other supplements you are currently taking, including dosage (attach list if needed): _____

_____

_____

I certify that the above information is correct and will notify my Periodontist or Hygienist of any changes.

Patient/Parent Signature: _____ Date: _____

Notes: _____

_____

_____

_____

Reveiwed by: _____ Date: _____