Perio4U Medical History Form

Patient last name_____ First name _____ Date of birth ___ /___ /___ Sex oM oF

Please answer all questions by marking Yes or No. Your response to this questionnaire will be held strictly confidential and will only be used to assist in the assessment of your medical condition and treatment. If you have any hesitations, please discuss your concern with the Doctor. Please inform your doctor of any future changes.

Do you have or have you had any of the following:

Cardiovascular disorders

Yes	No	
o	o	High blood pressure
o	o	Congenital heart disease
o	o	Rheumatic fever
o	o	Heart murmur
o	o	Heart pacemaker
o	o	Vascular graft
o	o	Heart or bypass surgery
o	o	Artificial heart valve
o	o	Heart attack
o	o	Congestive heart failure
o	o	Awaken with breathing problem
o	o	Angina pectoris/ chest pain
o	o	Swollen ankles
o	o	Irregular or rapid heartbeat
o	o	Stroke

Respiratory disorders

Yes	No	
o	o	Emphysema
o	o	Asthma
o	o	Hay fever
o	o	Chronic cough/bronchitis
o	o	Tuberculosis (TB)
o	o	Chronic sinusitis
o	o	Breathing problems
o	o	Rhinitis
o	o	COVID-19 infection
o	o	COVID vaccination

Musculo-skeletal/ CNS/ developmental disorders

Yes	No	
o	o	Frequent headaches
o	o	Fainting or loss of Consciousness
o	o	Seizures or epilepsy
o	o	Visual impairment
o	o`	Glaucoma
o	o	Hearing impairment
o	o	Artificial joint
o	o	Arthritis or bone disease
o	o	Muscle disease
o	o	Spinal cord injury
o	o	Osteoporosis
o	o	Paralysis
o	o	Cerebral palsy
o	o	Parkinson's disease
o	o	Myasthenia Gravis
o	o	Autism spectrum
o	o	Intellectual disability
o	o	Alzheimer disease/ dementia

Gastrointestinal/Genitourinary disorders

Yes	No	
o	o	Colitis or ulcer
o	o	Hepatitis or other liver disease
o	o	Jaundice
o	o	Renal dialysis/transplant
o	o	Kidney disease
o	o	Syphilis, gonorrhea or other sexually transmitted diseases
o	o	Genital Herpes
o	o	Frequent canker sores
o	o	Frequent cold sores
o	o	Chronic Diarrhea
o	o	Frequent vomiting /Acid reflux
o	o	Special diet
o	o	High Cholesterol

Hematologic/ Endocrine/ Immune disorders

Yes	No	
o	o	Blood transfusion
o	o	Denied permission to give blood
o	o	Anemia
o	o	Polycythemia
o	o	Leukemia/Lymphoma
o	o	Hemophilia
o	o	Sickle cell disease
o	o	Blood clots or thrombosis
o	o	Bleeding or bruising tendency
o	o	Thyroid disease
o	o	Adrenal gland disease
o	o	AIDS/ HIV infection
o	o	Abnormal blood cell counts
o	o	Diabetes
o	o	Frequent thirst
o	o	Frequent hunger
o	o	Frequent urination
o	o	High Cholesterol
o	o	Weight loss or gain
o	o	Cancer (Type: _____)
o	o	Radiotherapy/chemotherapy
o	o	Systemic lupus
o	o	Pemphigus
o	o	Pemphigoid

Psychiatric

Yes	No	
o	o	Nervousness/Anxiety
o	o	Depression
o	o	Schizophrenia
o	o	Past/present psychiatric Treatment
o	o	Dental Phobia

Family history (Grandparents, parents, sisters, brothers, children)

Yes	No	
o	o	Diabetes
o	o	Heart disease
o	o	Cancer
o	o	Bleeding disorders

Allergies:

Yes	No	
o	o	Penicillin/ Amoxicillin
o	o	Sulfa drugs
o	o	Dental anesthetic
o	o	Aspirin/ Ibuprofen/NSAIDS
o	o	Codeine
o	o	Latex products
o	o	Other_____

Females:

Yes	No	
o	o	Are you pregnant?
o	o	Anticipating Pregnancy?
o	o	Are you breast-feeding?
o	o	On birth control pills?

Do you have any other condition, disease or problem not mentioned above?

_____
_____

Have you ever been hospitalized before? **Yes o** **No o**
List of surgical procedures you have had:

_____
_____

Social History:

Have you been a smoker before? **Yes o** **No o**
Do you currently use tobacco? **Yes o** **No o**
Would you like to quit? **Yes o** **No o**
What kind? _____
How much? _____
How many years? _____

Do you drink alcoholic beverages? **Yes o** **No o**
What kind? _____
How much per day? _____
How many years? _____

Past or present history of drug addiction **Yes o** **No** o
Past or present history of alcoholism **Yes o** **No o**

Are you under care of a physician? **Yes o** **No o**
If yes, please provide us the name and phone number of your physician(s):

_____
_____
_____

Current Medications:

Prescribed and over-the-counter medications taken within the last six months.

Medication **Dosage** **Reason**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Dental history:

Chief complaint/ Area of concern: _____

Has your dental care been: **o Regular** **o Intermittent (when necessary)** **o Infrequent (when in pain?)**

o Yes **o No** Unpleasant experience in a dental office
o Yes **o No** Feel apprehensive about visiting dental office
o Yes **o No** Injury to your face, neck and jaws
o Yes **o No** Pain upon opening or closing your mouth
o Yes **o No** Pain in the face, neck, or jaws
o Yes **o No** Dissatisfied with the appearance of your teeth
o Yes **o No** Grind or clench your teeth
o Yes **o No** Lesion, mass or soreness in your mouth

Approximate date when your teeth were last cleaned: _____

What aids and how often do you use them to clean your teeth and gums? _____

Is there any sensitivity in your teeth? **o Tooth brushing** **o Hot** **o Cold** **o Sweet** **o Biting** **o Pressure** **o None**

Have you ever had any of these treatments? **o Periodontal o Orthodontic o Endodontic o None** When? _____

Have you ever experienced any of the following?

o Bleeding gums **o Swelling of gum** **o Spaces between teeth** **o High or rough fillings**
o Receding gums **o Loose teeth** **o Pus around the teeth** **o Drifting of teeth**
o Bad breath **o Foul odor** **o Pain and soreness in gums** **o Food packing between teeth**

How did you first discover you had a gum problem? _____

How long have you been aware of a gum problem? _____

To the best of my knowledge, all of the preceding answers are true. If I ever have any change in my health, or if my medications change, I will inform my dental health care provider at my next appointment.

Signature of the patient_____ Doctor Signature _____Date ___ /___ /___
Signature of the patient_____ Doctor Signature _____Date ___ /___ /___
Signature of the patient_____ Doctor Signature _____Date ___ /___ /___