

Periodontal Patient Information Questionnaire

Coast Periodontics & Laser Surgery • Lynn C. Sayre-Carstairs, DMD, Inc.

Patient Name: _____ How would you like to be addressed: _____
Age: _____ Date of Birth: _____ Male Female Single Married Other Minor
Mailing Address: _____ City: _____ St: _____ Zip: _____
Home Phone: (____)____-____ x____ Alternate Phone: (____)____-____ x____ Bus. Phone: (____)____-____ x____
Social Security #: _____ Driver's License: _____ Email: _____
Occupation: _____ Employer: _____
Dental Insurance: _____ Group #: _____
Referred By: _____ Purpose of Initial Visit: _____
Family Dentist: _____ City: _____ How Long: _____ Last Cleaning _____
Family Physician: _____ City: _____ How Long: _____
Physician's Phone #: (____)____-____ Physician's Fax #: (____)____-____ Last Physical Exam: _____
Spouse's Name (Parent or Guardian if minor): _____ Date of Birth: _____
Occupation: _____ Employer: _____ Bus. Phone: (____)____-____ x____
Social Security #: _____ Dental Insurance: _____ Group #: _____

Oral History

(Please Check Y = Yes; N = No)

Present Dental Complaint? _____
Do you have an unpleasant taste or odor in your mouth? Y N Are your teeth sensitive? Y N
Do your gums bleed? If so, when? Y N Are your gums sore or swollen? .. Y N
Are you unhappy with the appearance of your teeth? Y N Does your jaw click or pop? Y N
Do you clench or grind your teeth? Y N
Have you ever had orthodontic treatment (braces) Y N
Have you had periodontal treatment previously? By whom? _____ Y N

Health History

Height _____ Weight _____ How is your general health? GOOD FAIR POOR
Are you now being treated or have you been treated within the last year by a physician? Y N
Have you ever had any surgery? Y N Do you have any artificial joints? Y N
Are you now taking any medication, drugs, or pills? INCLUDING ASPIRIN, VITAMINS & HERBS Y N
If yes, please list all medications: _____

Have you taken cortisone/steroids in the last year? Y N
HAVE YOU EVER EXPERIENCED A REACTION TO ANY OF THE FOLLOWING?
Aspirin Y N Latex Y N Dental Anesthetics (Novocaine) Y N
Penicillin Y N Iodine Y N Antibiotics (which ones) _____ Y N
Codeine Y N Sleeping Pills Y N Other Drugs _____ Y N

HAVE YOU EVER HAD:
Heart trouble Y N Hepatitis (liver disease) Y N
Heart murmur or Mitral Valve Prolapse Y N Diabetes (sugar in blood) Y N
Stroke Y N Anemia or any abnormal blood counts Y N
High blood pressure Y N Thyroid or parathyroid trouble Y N
Rheumatic fever..... Y N Convulsions Y N
Tumor or growth Y N Tuberculosis..... Y N
Radiation, Chemo, Cancer treatment Y N Asthma..... Y N
Arthritis, Rheumatism Y N Kidney Disease Y N
Jaundice (yellow skin & eyes) Y N Lung Disease Y N
Epilepsy or Seizure disorders Y N Ulcers or Stomach problems Y N
Bleeding problems/Blood Disorders Y N Intestinal Disorder Y N

Do you consider yourself a nervous person? Y N Do you get up often at night to urinate? How often? ____ Y N
Do you drink alcohol? How much? Y N Are you thirsty much of the time? Y N
Do you smoke? How Much? Y N Has anyone in your family had diabetes? Who? _____. Y N
Do you use chewing tobacco? Y N Have you tested HIV positive? Y N
Do you have AIDS or PRAIDS? Y N
Women only: Are you currently pregnant? Y N If yes, what month? __ Do you use birth control medication? Y N

Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? Y N
Have you ever taken Bisphosphonates for osteoporosis, chemo therapy, multiple myeloma or other cancers (Fosomax, Actonel, Boniva, Aredia or Zometa)? Y N Would you like to speak to the doctor privately about any problem? Y N

TO BE SIGNED AND DATED IN DENTAL OFFICE

DATE _____ PATIENT/LEGAL GUARDIAN SIGNATURE _____

