***John E. Crosland,D.D.S.***
***Practice Limited to Periodontics***

Today's Date:_____
**Name:_____Birthdate_____**

**EXAMINATION AND HEALTH HISTORY QUESTIONAIRE**
**GENERAL DENTIST_____PHYSICIAN_____**
**REFERRAL MADE BY _____**

In order to evaluate your dental health thoroughly and completely, please complete the following examination prior to your dental appointment. This will become part of your office record and will be held in strict confidence.

1) Are you experiencing pain from your mouth at this time? _____If so, explain:_____
2) How many times have you had your teeth cleaned in the last 5 years? _____When was the last time?_____
3) Have you had previous periodontal treatments? _____ Dentist; Date:_____
4) Do your gums bleed? _____ When you brush? _____At night in sleep?_____
5) Have you noticed any loose teeth ?_____Shifting teeth?_____
6) Have you noticed any mouth odors or bad tastes? _____For how long?_____
7) Did either your mother, father, brother, or sister lose all of their natural teeth? _____Which?_____
8) Are your teeth sensitive to heat, cold or sweets? _____Which ones? _____
9) How often do you brush your teeth? _____How often do you floss your teeth? _____
10) Do you often have fever blisters on your lips? _____After dental care? _____
11) Have you had your teeth straightened? _____Dentist, Date_____
12) Have you been under more nervous tension than average lately? _____
13) Do you smoke? _____What and how much? _____
14) Are you aware of grinding you teeth? _____At night? _____
15) Do you have clicking? _____Popping? _____Pain? _____ in the jaw joints.
16) Do you have headaches regularly? _____Mornings? _____Evenings? _____After eating? _____
17) Have you ever had an extremely frightening experience with dentistry? _____Explain _____
_____
18) Are you fearful of undergoing periodontal therapy? _____Why? _____
19) Have we treated any of your family or friends? _____Who? _____
20) Please indicate the items you regularly use to care for your mouth: _Hand toothbrush
__Electric Toothbrush ___ Dental Floss __Rubber Stimulator __Toothpicks ___Perio Aid
___Stimudents __Water Pik __ Disclosing Solution ____Other
21) Do you consider your general health to be good? _____Fair?_____Poor?____
22) Your last physical evaluation was on ? _____
23) Has your general health changed within the past year?_____ If yes, explain: _____
_____
24) Have you ever fainted? _____In a dental office? _____
25) Are you taking any medications, drugs, pills regularly? _____If so, list name and amount of dosage:
_____
_____
26) Are you being treated by a physician at this time? _____ If so, why? _____
_____
27) Have you ever had, or do you now have any of the following?

| | | | |
|---|---|---|---|
| ____Anemia | ____Heart Disease | ____Low blood pressure | ____Arthritis |
| ____Blood Disease | ____Stroke | ____Diabetes | ____Rheumatism |
| ____Bleeding Problems | ____Rheumatic fever | ____Venereal Disease | ____Lung trouble |
| ____Clotting Problems | ____High blood Pressure | ____Hepatitis | ____Asthma |

____Tuberculosis ____Excessive thirst ____Psychiatric treatment ____Skin disease
____Ulcer(s) ____Liver trouble ____Glaucoma ____Thyroid disease
____Bowel disease ____Gland trouble ____Sinus trouble ____Malignancy
____Kidney disease ____Bladder trouble ____Epilepsy ____Radiation therapy
____Aids ____HIV ____Other_____

28) Have you ever taken cortisone?_____When and for how long?_____
29) Have you taken anti-coagulants (blood thinner)? _____When and for how long? _____
30) Circle or note the drugs you have reacted adversely to:

Penicillin Aspirin Codeine Novacaine Demoral
Anthihistamines Barbiturates Local Anesthetics Darvon Antibiotics
Other:_____

31) Do you bruise easily?_____
32) Have you had surgery? _____ When?_____ Any Complications _____
For what?_____
33) Are you on a special diet, to lose weight, low salt, diabetic, cholesterol, food allergy? _____
34) Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your periodontal care:

_____
_____

Women: Are you pregnant?_____Which month?____Oral contraceptives?_____
Have you reached menopause?_____Are you taking hormones?_____

Please circle the number on the following scale which best describes your feeling about retaining your remaining teeth:

Makes no difference 1-2-3-4-5-6-7-8-9-10 very important

Person to notify in case of emergency
Name: _____
Address: _____
_____
Home Phone: _____
Business Phone:_____

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED:_____DATE:_____

OFFICE USE:
DATE:_____BP_____PULSE_____
REVIEWED BY:_____
COMMENTS: