Medical and Dental History

Gillihan PERIODONTICS

Welcome! We are pleased to welcome you to our practice. Please fill out this form as completely as you can. The following information is essential for our doctor and staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently treat your dental needs.

Name: _____ DOB: _____Age: _____

Physician: _____ _____ Phone: _____ Date of last visit: _____

Circle what best describes your current physical health: good fair poor

Answer each question. Check yes or no. if in doubt, leave blank:	YES	NO
1. Are you under the care of a physician?		
• If so, what is the condition being treated? _____		
2. Have you ever been hospitalized or had a serious illness?		
• If yes, describe: _____		
3. List any surgeries you have had: _____		
4. Have you ever had excessive bleeding after a tooth extraction?		
• Do cuts take longer to heal now than before?		
5. (Women) Are you pregnant? If so, due date: _____		
6. (Women) do you use birth control pills?		
7. Do you use tobacco?		
• If yes, what kind and how much/often:_____		
8. Do you consume more than two alcoholic beverages per day?		

9. List all current medications (including over the counter) and their dosages:

_____

_____

_____

10. Are you allergic or have you experienced any reactions to the following?

	YES	NO
Penicillin		
Sulfa Drugs		
Other Antibiotics		
Aspirin		
Local anesthetics (e.g. Novocain)		
Codeine		
Other drug allergies:_____		

PLEASE COMPLETE OTHER SIDE

Phone: (816) 373-5400 3151 S. 291 Hwy, Independence, MO 64057 Fax: (816)373-5401

11. Do you have or have you had any of the following?

	YES	NO
BLOOD		
ARC / AIDS		
Bruise easily		
Hemophilia		
HIV positive		
BONE/MUSCLE		
Arthritis/rheumatism		
Artificial joints		
Bisphosphonate therapy, oral or IV		
Osteoporosis		
DIGESTIVE SYSTEM		
Hepatitis		
Jaundice		
Ulcers		
EARS		
Loss of hearing		
ENDOCRINE		
Diabetes		
Family history of diabetes		
Thyroid condition/goiter		
Other_____		
EYES		
Glaucoma		
Visual change		
GENERAL		
Marked weight loss		
Tire easily, weakness		
URINARY		
Kidney disease		
Increase in frequency of urination (night).		
Venereal disease		
SKIN		
Change in skin color		
Eruptions (rush) hives		

	YES	NO
HEART/BLOOD VESSELLS		
Artificial heart valve		
Congenital heart disease		
Have taken Fen-Phen		
Heart attack/trouble		
Heart murmur		
Heart surgery		
High blood pressure		
Low blood pressure		
Pacemaker		
Prolapsed mitral valve		
Rheumatic fever		
Swelling of ankles		
Other_____		
NERVOUS SYSTEM		
Convulsions/epilepsy		
Dizziness/fainting		
Headaches		
Psychiatric treatment		
Stroke		
RESPIRATORY		
Asthma		
Cough up bloody sputum		
Difficulty breathing while lying down		
Emphysema		
Persistent cough		
Shortness of breath		
Tuberculosis		
OTHER		
Chemotherapy		
Recreational drug use		
Other		
Other		
Other		

12. What is your primary dental concern? _____
13. Have you ever had any serious trouble associated with previous dental treatment? _____
14. Are you currently experiencing any pain in your mouth? _____
15. Does dental treatment make you nervous? No _____ Slightly ____ Moderately ____ Extremely _____
16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
    - If so, for what and when? _____
17. Have you been advised to take an antibiotic premedication prior to your dental appointment? _____
18. Do you have or have you had any of the following?

	YES	NO
Bleeding or sore gums		
Clenching or grinding		
Clicking/popping jaw		
Food impaction		
Loose teeth		
Shifting of teeth		

	YES	NO
Orthodontic treatment (braces)		
Teeth sensitive to biting		
Teeth sensitive to sweets		
Teeth sensitive to hot and/or cold		
Unpleasant taste / bad breath		

19. How often do you see your dentist (circle): 3 months 6 months 9 months Yearly Other_____
20. When were your teeth last cleaned? _____
21. How often do you brush? _____ Floss? _____
22. Do you use any other dental tools or products? _____ If so, what and how often? _____

I give permission to the doctor and staff at Gillihan Periodontics to administer medications and anesthetics necessary for proper periodontal/ dental care. Permission is also given to share information about my health and care to my referring dentist and insurance company as needed. I understand that I am fully responsible for all charges whether covered, not covered, or denied by insurance as allowable by the insurance provider contract. Payment is due at the time of service unless prior arrangements are made. The information I have filled out on the medical history and general information form is correct to the best of my knowledge. If any changes occur I will notify Gillihan Periodontics.

Signature: _____ Date: _____

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