# GENERAL HEALTH CHART

*Please Complete and Return*

Name _____ Address_____ City _____ State_____
Zip Code_____ Home Phone_____Bus. Phone _____ Date of Birth_____
Employer_____ Occupation _____ Insurance Co._____
SS# _____ Group# _____
Spouse's name_____ Spouses' Employer_____ Occupation _____
Spouse's Ins. Co. _____ Spouse's SS# _____Spouse's Group# _____
Dentist _____Physician _____

Since the cause of periodontal disease is a combination of many factors, and very complex, it is necessary to root out any possible causative factor. The success of the treatment depends upon this.

Although many of these questions may seem to have nothing to do with your gum condition, they are all related to possible contributing influences.

In the following questions, circle "yes" or "no", whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? . . . YES NO
   A. Has there been any change in your general health in the past year? . . . YES NO
      If answer is yes, what was the change? _____
2. When was your last physical exam? _____
3. Are you now under the care of a physician? . . . YES NO
   If answer is yes, what condition is being treated _____
4. Have you had any serious illness or operation? . . . YES NO
5. Have you been hospitalized or had a serious illness in the past five years? . . . YES NO
   If answer is yes, for what problem? _____
6. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease . . . YES NO
   b. Congenital heart lesions . . . YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary artery insufficiency, coronary occlusion, arteriosclerosis, stroke, heart murmur, or mitral valve prolapse) . . . YES NO
      1. Do you have chest pains upon exertion? . . . YES NO
      2. Do you have shortness of breath after mild exercise? . . . YES NO
      3. Do your ankles swell? . . . YES NO
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? . . . YES NO
      5. Do you have a cardiac pacemaker? . . . YES NO
      6. Do you have artificial joints or valves? . . . YES NO
      7. Do you have high blood pressure? . . . YES NO
   d. Allergy? . . . YES NO
   e. Sinusitis? . . . YES NO
   f. Asthma or hay fever? . . . YES NO
   g. Hives or a skin rash? . . . YES NO
   h. Fainting spells or seizures? . . . YES NO
   i. Diabetes? . . . YES NO
      1. Do you have to urinate more than 6 times a day? . . . YES NO
      2. Are you thirsty much of the time? . . . YES NO
      3. Does your mouth frequently become dry? . . . YES NO
   j. Hepatitis, jaundice or liver disease? . . . YES NO
   k. Arthritis? . . . YES NO
   l. Inflammatory rheumatism (painful swollen joints)? . . . YES NO
   m. Low blood pressure? . . . YES NO
   n. Herpes virus (cold sores)? . . . YES NO
   o. Stomach ulcers? . . . YES NO
   p. Kidney trouble? . . . YES NO
   q. Tuberculosis? . . . YES NO
   r. Venereal Disease? . . . YES NO
   s. Acquired Immune Deficiency Syndrome? . . . YES NO
7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? . . . YES NO
8. Do you have any blood disorder, such as anemia? . . . YES NO
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? . . . YES NO

(over)

10. Have you ever had a blood transfusion? . . . . . YES NO
If so, explain: _____
11. Have you ever had or are you currently taking kidney dialysis? . . . . . YES NO
If so, explain: _____
12. Are you taking any of the following:
a. Antibiotics or sulfa drugs? . . . . . YES NO
b. Anticoagulants (blood thinners)? . . . . . YES NO
c. High blood pressure medication? . . . . . YES NO
d. Cortisone (steroids)? . . . . . YES NO
e. Tranquilizers? . . . . . YES NO
f. Aspirin? . . . . . YES NO
g. Insulin, Tolbutamide (Orinase) or similar drug? . . . . . YES NO
h. Digitalis or drugs for heart trouble? . . . . . YES NO
i. Nitroglycerin? . . . . . YES NO
j. Antihistamine? . . . . . YES NO
k. Oral contraceptive or other hormonal therapy? . . . . . YES NO
13. Are you taking any other drug or medication not mentioned above? . . . . . YES NO
If so, specify: _____
14. Are you allergic or have you reacted adversely to:
a. Local anesthetics, novacaine? . . . . . YES NO
b. Penicillin or other antibiotics? . . . . . YES NO
c. Sulfa drugs? . . . . . YES NO
d. Barbiturates, sedatives, or sleeping pills? . . . . . YES No
e. Aspirin? . . . . . YES NO
f. Iodine? . . . . . YES NO
g. Codeine or other narcotics? . . . . . YES NO
h. Other _____
15. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiations? . . . . . YES NO
16. Are you wearing contact lenses? . . . . . YES NO
17. Have you ever been treated for Glaucoma? . . . . . YES NO
18. WOMEN - Are you pregnant? . . . . . YES NO

## — DENTAL —

19. Have you had any serious trouble associated with any previous dental treatment? . . . . . YES NO
20. Have you ever had an acute sore mouth? . . . . . YES NO
21. Do your gums bleed? When? . . . . . YES NO
22. Are you aware of a bad taste or odor in your mouth? . . . . . YES NO
23. Are you troubled with frequent gum boils? . . . . . YES NO
24. Does your jaw ever get “out of joint”? . . . . . YES NO
25. Do you ever have pain opening or closing your mouth? . . . . . YES NO
26. Did you ever wear braces for straightening your teeth? . . . . . YES NO
27. Have you ever had previous gum treatments? . . . . . YES NO
28. Have you ever smoked? . . . . . YES NO
29. Are you presently smoking? . . . . . YES NO

## ★ — INITIAL MEDICAL HISTORY —

1. _____
(DATE) (PATIENT OR GUARDIAN SIGNATURE) (HYGIENIST/ASSISTANT SIGNATURE)

## — UPDATE OF MEDICAL HISTORY —

2. _____
(DATE) (CHANGES)

_____

_____
(PATIENT OR GUARDIAN SIGNATURE) (HYGIENIST/ASSISTANT SIGNATURE)

3. _____
(DATE) (CHANGES)

_____

_____
(PATIENT OR GUARDIAN SIGNATURE) (HYGIENIST/ASSISTANT SIGNATURE)