WENDELL P. URLING, D.D.S.

PERIODONTICS AND ORAL DIAGNOSIS

HEALTH QUESTIONNAIRE

NAME _____ SEX _____ DATE _____
LAST FIRST MIDDLE

HOME ADDRESS _____ PHONE _____
STREET, CITY STATE ZIP

PERIODONTAL DISEASE AND OTHER CONDITIONS AFFECTING ORAL HEALTH MAY BE PRODUCED BY A VARIETY OF CONTRIBUTING FACTORS. SUCCESSFUL TREATMENT REQUIRES THAT THESE CAUSATIVE ELEMENTS BE PROPERLY DIAGNOSED. TO ACCOMPLISH THIS AND TO INSURE PROPER MANAGEMENT OF YOUR CASE, WE REQUEST THAT YOU COMPLETE THE FOLLOWING HEALTH QUESTIONNAIRE AS COMPLETELY AS POSSIBLE. IT WILL OF COURSE BE KEPT CONFIDENTIAL.

	YES	NO
PRESENT HEALTH:		
1. How would you describe your general health? _____		
2. Are you now or have you in the last five years been under the care of a physician? If yes, for what? _____	☐	☐
3. Date of last physical exam _____		
4. Weight _____ Height _____		
5. What medications are you presently taking? _____		
PAST MEDICAL HISTORY:		
6. Have you ever had any serious illness or operation? If yes, explain _____	☐	☐
CARDIOVASCULAR:		
7. Have you ever had heart trouble, murmurs, or a stroke?	☐	☐
8. Have you ever had rheumatic fever or rheumatic heart disease?	☐	☐
9. Have you ever had abnormally high or low blood pressure?	☐	☐
10. Have you ever taken anticoagulants (blood thinners)?	☐	☐
11. Have you ever had ankle swelling, shortness of breath, or chest pains?	☐	☐
BLOOD:		
12. Have you ever had any blood diseases?	☐	☐
13. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	☐	☐
14. Do you bruise or swell easily	☐	☐
15. Have you ever had anemia?	☐	☐
ENDOCRINE:		
16. Do you or any member of your family have diabetes?	☐	☐
17. Have you ever been treated for any endocrine or glandular disorders?	☐	☐
18. Do you heal rapidly, normally, or slowly? _____		
RESPIRATORY:		
19. Have you ever had tuberculosis, pneumonia, or pleurisy?	☐	☐
20. Do you have emphysema or difficulty breathing?	☐	☐
21. Do you have frequent colds or persistent coughs?	☐	☐
22. Do you breathe primarily through your mouth?	☐	☐
23. Do you smoke? If so, what and how much _____	☐	☐
NERVOUS:		
24. Are you an extremely nervous person?	☐	☐
25. Have you ever had any emotional problems?	☐	☐
26. Do you have frequent or severe headaches?	☐	☐
27. Have you ever experienced severe pains of the head or face?	☐	☐
28. Have you ever had epilepsy, convulsions, or fainting spells?	☐	☐
G.I. AND G.U.:		
29. Have you ever had hepatitis or yellow jaundice?	☐	☐
30. Do you have any liver or gall bladder disorders?	☐	☐
31. Have you ever had any kidney or bladder problems?	☐	☐
32. Have you ever had Venereal disease?	☐	☐
33. Do you have stomach ulcers or other gastro-intestinal problems?	☐	☐
34. Are you on any special diet?	☐	☐
35. Do you drink an excessive amount of alcohol?	☐	☐
ALLERGIES:		
36. Are you sensitive or allergic to any anesthetic (local or general), antibiotic (penicillin or tetracycline), pain medication, or other drug? If yes, explain _____	☐	☐
37. Do you have asthma, hay fever, sinusitis, or other allergies?	☐	☐
38. Have you ever had hives or a rash?	☐	☐

	YES	NO
OTHER:		
39. Do you have arthritis, joint, or muscular disorders?	☐	☐
40. Do you have any visual or hearing problems?	☐	☐
41. Have you ever had cancer, a tumor, or radiation therapy?	☐	☐
42. Have you ever been treated for any skin diseases?	☐	☐
43. Have you recently gained or lost substantial weight?	☐	☐
44. Have you ever taken corticosteroids?	☐	☐
45. Do you get infections easily?	☐	☐
FEMALES:		
46. Are you pregnant?	☐	☐
47. Do you have any problems associated with your menstrual period?	☐	☐
48. Are you presently undergoing or have you undergone menopause?	☐	☐
49. Have you ever taken birth control medication?	☐	☐
PRESENT DENTAL HEALTH:		
1. What is your present dental problem?_____		
2. Are you presently experiencing any pain or discomfort? If so, where?_____	☐	☐
3. Do you ever notice a bad taste or odor in your mouth?	☐	☐
4. Do your gums ever bleed? If so, when?_____	☐	☐
5. Have you ever noticed any loosening of your teeth or shifting of your bite?	☐	☐
6. Does your jaw click, pop, or cause pain on opening or closing?	☐	☐
7. Do you clench, grit, or grind your teeth (particularly at night)?	☐	☐
8. Are any of your teeth sensitive to pressure, hot, cold, or sweets?	☐	☐
9. Do you chew on one side of your mouth? If so, why?_____	☐	☐
10. When were your last full mouth X-Rays taken?_____		
11. When was your last dental cleaning?_____		
PAST DENTAL HISTORY:		
12. Have you ever had an acute sore mouth, canker sores, gum boils, or tongue pain?	☐	☐
13. Do you ever have fever blisters in your mouth or on your lips?	☐	☐
14. Have you previously undergone periodontal therapy? If so, when?_____	☐	☐
15. Have you ever worn braces to straighten your teeth?	☐	☐
16. How often have you seen a dentist in the past ten years?_____		
17. Have you ever been instructed in the prevention of gum disease and tooth decay?	☐	☐
18. How frequently do you brush your teeth?_____		
19. Do you use a soft, medium, or hard brush?_____		
20. Do you routinely use dental floss, stimudents, or a rubber tip?	☐	☐
21. Does food tend to wedge between any of your teeth?	☐	☐
22. Do you eat a lot of sweets?	☐	☐
23. Have you ever had any traumatic dental experiences?	☐	☐
24. Are you worried about undertaking periodontal treatment?	☐	☐
25. Are you presently dissatisfied with the appearance of your teeth?	☐	☐
26. Would you object to wearing dentures?	☐	☐
27. Do you have any disease, condition, or problem not listed above? If so, please explain._____	☐	☐
_____		

CONSENT FORM

I hereby state that the above health questionnaire has been answered to the best of my knowledge. I furthermore give my permission for the administration of those agents and for the performance of those procedures which are deemed necessary or advisable for the proper diagnosis and treatment of this case.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incapable.

Signature _____
Patient or Relative — Relationship

Witness _____ Date _____