PERIODONTICS HAWAII

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Diplomate of the Board of Periodontology
Board Certified Periodontist

NAME: ______________________________

INITIAL DATE: ________________________

For the following questions, check YES or NO, whichever applies. Your answers are for our records only, and will be confidential.

THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH

Sex: M / F Height:__________ Weight:__________ Age:________ Race:______________

YOUR MEDICAL HISTORY:

1. Are you in good general health?...yes / no
2. Has there been ANY change in your general health in the past year?..................................yes / no
3. My last PHYSICAL EXAM was on this date ______________________________
4. Are you PRESENTLY under a physician's care?...yes / no
   if YES, for what condition?______________________________
5. The physician's name and address:
   ____
6. Have you had any serious operation illness or operation?..yes / no
   if YES, please list
   ____
7. Have you been hospitalized or had a serious illness within the past 5 years?........................yes / no
   if YES, please reason
   ____

YOUR CARDIOVASCULAR SYSTEM:

CV1. Do you have or ever had any of the following, please check: ....yes / no

☐ Heart trouble ☐ Heart Attack ☐ Coronary insufficiency ☐ Stroke

☐ Damaged heart valves ☐ Congenital heart disease

CV2. Rheumatic heart disease, heart murmur?...yes / no
CV3. Chest pain after exertion?...yes / no
CV4. Shortness of breath after mild exercise?..yes / no
CV5. Do your ankles swell?..yes / no
CV6. Do you use extra pillows to sleep?..yes / no
CV7. Do you have a cardiac pacemaker?..yes / no
CV8. Do you have any blood pressure problems?...yes / no
If YES, what are they?
____
____

YOUR CENTRAL NERVOUS SYSTEM:

CN1. Do you have or ever had:
  CN1A. Epilepsy?...yes / no
  CN1B. Fainting spells?...yes / no
  CN1C. Seizures?...yes / no
  CN1D. Emotional disturbances?...yes / no
CN2. Do you follow any treatment for a nervous disease?...yes / no

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YOUR BONES AND JOINTS:

BJ1. Do you have:

- BJ1A. Arthritis?..yes / no
- BJ1B. Inflammatory rheumatism?..yes / no
- BJ1C. Bone infection?..yes / no
- BJ1D. Osteoporosis?..yes / no
- BJ1E. Taken Bisphosphonates?..yes / no

YOUR NEOPLASM:

TR1. Do you have or have you ever had:

- TR1A. Tumor or malignancy?..yes / no
- TR1B. Chemotherapy, or radiation therapy?..yes / no

TR2. Do you have or have you ever had A<u>NY</u> disease, condition or problem <u>NOT</u> listed above that you think we should know about?..yes / no

If so, please explain:______________________________

TR3. Are you regularly exposed to x-rays?..yes / no

- TR3A. <u>ANY</u> other ionizing radiation or toxic substances?..yes / no

TR4. Do you have Glaucoma?..yes / no

TR5. Are you wearing or do you wear, contact lenses?..yes / no

TR6. Do you drink alcohol?..yes / no

- If so, how much and how often?______________________________

TR7. Do you use tobacco products?..yes / no

- If so, what type and how often?______________________________

YOUR MEDICATIONS:

ME1. Are you taking any of the following medications?

- ME1A. Antibiotics or sulfa drugs?..yes / no
- ME1B. Anticoagulants, blood thinning agents?..yes / no
- ME1C. Medicine for high blood pressure?..yes / no
- ME1D. Tranquilizers?..yes / no
- ME1E. Iodine?..yes / no
- ME1F. Codeine or other narcotics?..yes / no
- ME1F. Other medications you are taking:

____

____

____

FOR WOMEN ONLY:

FE1. Are you pregnant?..yes / no

FE2. Are you nursing?..yes / no

FE3. Do you have any problems with your menstrual period?..yes / no

FE4. Are you taking contraceptives or hormone replacement therapy?..yes / no

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YOUR RESPIRATORY SYSTEM:

RS1. Do you have persistent cough or cold?....yes / no
RE2. Do you have or have you ever had tuberculosis?....yes / no
RE3. Is there ANY history of Tuberculosis in your family?....yes / no
RE4. Do you have any sinusitis, sinus trouble?....yes / no
RE5. Do you have emphysema, chronic bronchitis, asthma?....yes / no

YOUR DIGESTIVE SYSTEM:

GI1. Do you have ANY stomach ulcers?....yes / no
GI2. Do you have or have you ever had:
- GI2A. Hepatitis?....yes / no
- GI2B. Jaundice?....yes / no
- GI2C. Liver disease?....yes / no

GI3. Have you ever vomited blood?....yes / no
GI4. Do you have ANY diarrhea?....yes / no

YOUR ENDOCRINE SYSTEM:

EN1. Do you have diabetes?....yes / no
EN2. Does anyone in your family have diabetes?....yes / no
EN3. Do you urinate more than 6 times/day?....yes / no
EN4. Are you thirsty very often or do you have a dry mouth?....yes / no

YOUR HEMATOPOIETIC SYSTEM:

HB1. Do you have anemia, Sickle Cell disease, blood disorder?....yes / no
HB2. Is there ANY family history of blood disorders?....yes / no
HB3. Are you hemophilic?....yes / no
HB4. Have you had abdominal bleeding after any surgery, extraction, or trauma?....yes / no
HB5. Have you ever had a blood transfusion?....yes / no
HB6. Any immunodeficiency problems? HIV?....yes / no

YOUR ALLERGIES:

AL1. Are you allergic to or have you acted adversely to?
- AL1A. Local anesthetics?....yes / no
- AL1B. Antibiotics, sulfa drugs, Penicillin....yes / no
- AL1C. Barbituates, sedative, or sleeping pills?....yes / no
- AL1D. Aspirin?....yes / no
- AL1E. Iodine?....yes / no
- AL1F. Codeine or other narcotics?....yes / no
- AL1G. Other, Please specify:

____

____

AL2. Do you have asthma or hay fever?....yes / no
AL3. Do you have or have you ever had hives or skin rash?....yes / no

YOUR GENITOURINARY SYSTEM:

UR1. Do you have or have you ever had
- UR1A. Kidney trouble?....yes / no
- UR1B. Syphilis, gonorrhea?....yes / no
- UR1C. Genital herpes?....yes / no

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YOUR DENTAL HISTORY:

What is your chief dental complaint?____

Are you in any discomfort or pain at this time?...yes / no

Are you satisfied with the appearance of your teeth?...yes / no

Are you able to eat and chew foods satisfactorily?...yes / no

Do you have headaches, ear aches, or neck pain?...yes / no

Do you frequently experience sinus problems?..yes / no

Have you had ANY serious trouble associated with ANY previous dental treatment?......................yes / no

If yes, please explain:

____

____

____

OTHER CONDITIONS NOT LISTED:

____

____

____

GENERAL DENTAL RESPONSIBILITY AND CONSENT STATEMENT:

I hereby authorize and request the performance of dental services for myself or for:

____________________ ____________________

I also give my consent to ANY advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Aaron J. Colby DDS MS for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and it's fee modification.

To the best of my knowledge the information provided in this form is accurate.

____________________	____________________
Signature of Patient or Guardian	Date
Signature of Witness	Date
Signature of Doctor	Date

Hawaii Kai

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