Winnipeg
PERIODONTAL GROUP
PERIODONTICS & IMPLANT DENTISTRY

Name: _____ Date: _____

MEDICAL HISTORY

Date of Last Physical Exam: _____
Are you presently under a physician's care? If yes, for what condition?

Have you ever been hospitalized? If yes, for what condition?

Do you have or have you had any of the following problems?

	YES	NO
1. Hepatitis, jaundice or liver disease?		
2. Rheumatic fever		
3. Heart murmur		
4. Heart trouble or stroke		
Do any blood relatives have heart trouble?		
5. Blood pressure: high ☐, low ☐, normal ☐		
6. Chest pains, ankle swelling or shortness of breath		
7. Drug allergies or reactions		
If yes, what:		
8. Asthma, hay fever, sinus problems or allergies		
If yes, what:		
9. Epilepsy or seizures		
10. Diabetes		
a) Any blood relatives?		
b) Do you urinate frequently?		
c) Are you often thirsty?		
11. Arthritis or rheumatism		
12. Stomach or duodenal ulcers		
13. Kidney disease or infection		
14. Venereal disease		
15. Have Acquired Immune Deficiencies Disease (AIDS)?		
16. Have you HIV Infection?		
17. Medical radiation treatments		
18. Glaucoma		
19. Have you had cataract surgery?		

	YES	NO
20. Have you ever had a blood transfusion?		
21. Abnormal bleeding problems or blood disorders		
a) Anemia		
b) Clotting problems		
c) Other blood problems		
22. Do you take any drugs or medicines?		
If yes, what:		
Bring a list.		
23. Have you taken any other medications within the past year?		
If yes, what:		
24. Are you a nervous person?		
If yes, do you take medication for this condition?		
25. Do you wear contact lenses?		
26. Have you any other serious illness or conditions which we should know about?		
If yes, what:		
27. Do you smoke?		
If yes, how much?		
Men:		
28. Prostrate problems?		
Women:		
29. Are you pregnant?		
30. Do you take birth control medication?		
31. Are you post-menopause?		
32. Do you have problems with your menstrual cycle?		

Other

DENTAL HISTORY

	YES	NO
1. Have you ever been told you have gum disease?		
2. Have you ever had treatments for periodontal disease?		
3. Do your gums bleed?		
4. Do your teeth feel loose?		
5. Do you grind or clench your teeth or jaws during the day or night?		
6. Do you have sore or sensitive teeth? (temperature, bite)		
7. Do you have pain elsewhere in your face or jaws?		
8. Do you have headaches, neck pain, jaw pain?		
9. Does your jaw make a popping noise, clicking, grinding?		
10. How long have you known about your gum condition?		

	YES	NO
11. Has your jaw ever locked or slipped out of place?		
12. Have you ever had your teeth straightened? (Orthodontics)		
13. How often do you brush your teeth?		
14. Do you use dental floss ☐, toothpicks ☐ Water irrigating device ☐, stimudents ☐		
If yes, how often:		
15. How often do you have your teeth cleaned at your dentist?		
16. When was your last cleaning at your dentist?		
17. Do or did your parents have their natural teeth?		
18. Are there or have there been any gum problems in your family?		
19. Does it hurt to chew?		

Other

Signature: _____ Initials: _____