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Implants

Periodontics

DENTAL HEALTH HISTORY:

Has your dental care been: Regular Intermittent Infrequent (when in pain)

Do you feel apprehensive about visiting our office? yes no

What aids do you use to clean your teeth and gums? _____

When were your teeth last cleaned (approximate date)? _____

Would you be very disturbed if you had to wear false teeth? yes no

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

When did you first learn that you had gum problems? _____

Have you ever experienced any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> pus around the teeth | <input type="checkbox"/> foul odor |
| <input type="checkbox"/> swelling of gums | <input type="checkbox"/> loose teeth | <input type="checkbox"/> bad breath or taste |
| <input type="checkbox"/> pain or soreness in the gums | <input type="checkbox"/> spaces between teeth | <input type="checkbox"/> food packs between teeth |
| <input type="checkbox"/> receding gums | <input type="checkbox"/> drifting of teeth | <input type="checkbox"/> high or rough fillings |

Is there sensitivity in your teeth with: hot cold sweets biting/pressure brushing

Do you suffer from pain in the face, neck or jaws? yes no

Have you ever had a local anesthetic (Novocaine, etc.)? yes no

Have you ever had an adverse reaction to a local anesthetic? yes no

Have you ever had any serious trouble with any previous dental treatment? yes no

If yes, explain: _____

How long since your last full-mouth X-Rays? _____

How long since your last dental treatment or visit? _____

MEDICAL HISTORY:

How would you describe your general health

good fair date of last medical _____

Age _____ Sex _____ Weight _____

Have you been a patient in a hospital during the past 2 years? yes no

Have you been treated by a medical doctor in the past 2 years? yes no

Following injuries or dental treatment have you had any bleeding problems? yes no

Is there any history of diabetes in your family? yes no

Have you received injections of steroids such as Cortisone? yes no

Make a checkmark only if your answer is "yes":

Have you become sick from, shown an allergy to, or been told not to take any of the following:

- Antibiotics (penicillin, tetracycline...)
- Analgesics (codeine, aspirin, tylenol, motrin...)
- Novocaine or other dental anesthetics
- Any other drugs or medicines _____

Are you now:

- Pregnant
- On a prescribed diet
- Using hormones (including birth control pills)
- Using anticoagulants (blood thinner)
- Using dilantin, cyclosporine A, nifedipine
- Using aspirin

Have you ever had any of the following:

- | | <u>Y</u> | <u>N</u> |
|---|--------------------------|--------------------------|
| AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism/Drug addiction | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis, sore joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve or joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood trouble (anemia, leukemia) | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain or tight feeling in chest | <input type="checkbox"/> | <input type="checkbox"/> |
| Clotting disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart lesions | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting spells, convulsions, epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Fen/Phen diet drug combination | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack or angina | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur or mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, liver disease or jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung trouble (TB, asthma, chronic cough) | <input type="checkbox"/> | <input type="checkbox"/> |
| Yeast infections or Thrush | <input type="checkbox"/> | <input type="checkbox"/> |
| Radium, X-ray or cobalt treatments | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Syphilis or other VD | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid or parathyroid trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumor or growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |