Progressive Periodontics & Implant Dentistry
MARC E. GORDON D.M.D.

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment, Angina (Chest pain), or Heart Attack
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Arrythemia
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Dizziness
- ❑ Stroke
- ❑ Hepatitis, Liver Issues
- ❑ Tuberculosis
- ❑ Sleep Apnea; C-PAP Msachine
- ❑ Thyroid Issues
- ❑ Sinus Issues

- ❑ Osteoporosis or Osteopenia

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Quit what year:_____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids

Are you taking or have you ever taken:

- ❑ Osteoporosis (bone density) medicine

In-Hospital Surgery (List):

_____
_____
_____
_____
_____

Women:

- ❑ May be pregnant

  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed above?_____
_____

Name, Specialty, and address of your physicians:

_____

_____

Please add anything else you would like us to know about:_____

_____

_____

Please List all current medications you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of patient (or parent/guardian): _____

Date: _____

_____

Dr. Notes:

_____

_____

_____

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DENTAL HISTORY

Please describe your chief oral complaint or concern:

_____
_____
_____

	Yes	No
Are you sensitive to:		
Heat	❑	❑
Cold	❑	❑
Sweets	❑	❑
Chewing	❑	❑
Do you have any food traps?	❑	❑
Do your gums ever feel tender, swollen?	❑	❑
Do your gums bleed?	❑	❑
Do your teeth feel loose?	❑	❑
Have you been treated for Periodontal Issues?	❑	❑
Do you floss?	❑	❑
How often ___ / Wk		
Have you had previous injuries to your face/jaw?	❑	❑
Do you have loose or broken fillings?	❑	❑
Do you clench or grind your teeth?	❑	❑
Has your bite ever been adjusted?	❑	❑
Do your jaws ever feel tired or ache?	❑	❑
Can you chew comfortably?	❑	❑

	Yes	No
Have your teeth shifted?	❑	❑
Do you have regular dental cleanings?	❑	❑
When was your last cleaning? _____		
Do you like the appearance of your smile?	❑	❑
Are you a nervous dental patient?	❑	❑
Do you have bad breath?	❑	❑
When was your last dental visit? _____		

If you could improve your teeth or smile, what would you do:

_____
_____
_____
_____

Additional Dental Information you would like to provide:

_____
_____
_____
_____