McClain & Schallhorn
PERIODONTICS
IMPLANT DENTISTRY

Date ______________________

Name		Date of Birth	
Occupation	Telephone (Home)	(Mobile)	(Work)
Last Medical Examination Blood Taken?	Findings	Physician(s) Name & Telephone	
General Dentist	Have Family or Friends Been Treated Here?		

PRESENT DENTAL COMPLAINTS

DENTAL HISTORY

	Yes	No
Do you fear dental treatment		
Have you ever been treated for periodontal disease		
Do your gums bleed		
Do you have difficulty chewing your food		
Do you grind or clench your teeth		
Do you have a bite guard/splint		
Are spaces developing between your teeth		
Have you noticed your bite changing		
Are you aware of breath odor		
Do you have frequent cold/canker sores		
Do you have pain in the jaw joints (TMJ)		
Have you ever had orthodontic treatment to straighten your teeth		
Does food wedge between your teeth		
Has any member of your family lost all their teeth		
Would you be tremendously disturbed to lose all of your teeth		
Are you having pain or discomfort at this time		
Do you have a strong gag reflex		

When was your last dental cleaning ____________________________

How often have your teeth been cleaned in the past 3 years ______

How long have you been a patient of your present dentist ________

How long have you known about your gum condition ___________

Are your teeth sensitive to: Hot _____ Cold _____ Sweet ____

Are you satisfied with the appearance of your teeth Yes ___ No ___

If no, why not ____

How would you rate your past dental care ____________________

Do you desire nitrous oxide during treatment __________________

Are you available on short notice for appointments Yes ___ No ___

Please check any of the following items used in mouth care:

Hand toothbrush............. _______

Type / Frequency ______________________

Electric toothbrush .... _______

Type / Frequency ______________________

Dental floss / Frequency ...... _______

Proxabrush .... _______

Toothpicks .... _______

Water spray device .. ______

Toothpaste .... ______

Type ______________________

Mouthwash .... ______

Type ______________________

Other ____________________

DENTAL HISTORY NOTES..

TURN OVER ➔

B.P.	Pulse

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
Heart attack or stroke, Heart disease _______________		
Heart murmur or valve problem		
Artificial heart valve		
Angina pectoris (Chest pain)		
Shortness of breath		
Swelling in ankles		
High blood pressure		
Heart pacemaker		
Abnormal bleeding problems or blood disorder		
Diabetes		
Or family history of diabetes		
Hepatitis or liver disease		
Thyroid or parathyroid disease		
Stomach or duodenal ulcers		
Gastro-esophageal reflux (GERD)		
Kidney disease		
Prostate issues		
Seizure Disorder (Epilepsy)		
Glaucoma		
Osteoporosis or osteopenia		
Medication for osteoporosis/osteopenia ______________		
Arthritis		
Osteoarthritis or Rheumatoid (circle one)		
Artificial joint replacement		
Orthopedic screws, pins, etc.		
Autoimmune Condition		
Emphysema or chronic bronchitis		
Lung disease		
Tuberculosis		
Sleep Apnea / Device (List) ___________________________		
Asthma		
Drug reaction to penicillin, erythromycin, clindamycin, tetracycline, codeine, Demerol, Percodan, Percocet, aspirin, ibuprofen, nitrous oxide, other _________________		

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
HIV or AIDS		
Cold sores or oral Herpes		
Cancer or abnormal growth		
Radiation or chemotherapy		
Anticoagulants (blood thinners)		
Alcoholism		
Drug addiction		
Eating disorder (anorexia, bulimia, etc.)		
Depression		
Any serious illness, disease, condition, not listed: ____ ____ ____		

ARE YOU:

Claustrophobic		
Under unusual stress		
Taking medication for anxiety/depression		
Taking sleeping medication		
Undergoing psychological treatment		
Do you wear contact lenses		
Do you currently use tobacco products		
Type ________________________________ Amount ____________________________		
Have you used tobacco products in the past		
Do you use Cannabis or THC products		
Type ________________________________ Amount ____________________________		

IF FEMALE, are you now (please check if yes)

Pregnant _______ Nursing _______

Anticipate becoming pregnant ______

Presently in (or post) menopause ___________

Taking oral contraceptives ______

Hormone Replacement Therapy ______

LIST CURRENT MEDICATIONS, SUPPLEMENTS & VITAMINS (ATTACH A LIST IF NECESSARY):

Prescription: ____

____

____

Over-the-Counter: ____

____

PAST SURGERIES OR HOSPITALIZATIONS: ____

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor or his/her staff at the next appointment without fail.

DATE: ________________________________ PATIENT'S SIGNATURE____
(Guardian/Parent if minor)