ANCHOR
PERIODONTICS
Periodontal & Implant Center

HEALTH HISTORY

Ranjitha Krishna, D.M.D

PATIENT'S FULL NAME:_____________________________________ **TODAY'S DATE:**________________

PATIENT'S PREFERRED NAME:____________________ **REFERRED BY:**___________________________

DATE OF BIRTH:_____/_____/_____ GENDER:______ HEIGHT:_____ WEIGHT:______

HOME ADDRESS:____

TELEPHONE NUMBER:________________(H) __________________(W) ________________(C)

MARRIED____ DIVORCED____ SEPARED____ SINGLE_____ WIDOWED________

EMERGENCY CONTACT:____________________________ PHONE NO.________________________

PATIENT'S EMAIL_________________________________ SPOUSE:_________________________

EMPLOYER_____________________________________ EMPLOYER_______________________

OCCUPATION___________________________________ OCCUPATION_____________________

SS#____ SS#____________________________

DENTAL INSURANCE? YES____ NO___ DENTAL INSURANCE? YES___ NO____

INSURANCE CO_________________________________ INSURANCE CO___________________

GROUP NO____________________________________ GROUP NO_______________________

POLICY NO____________________________________ POLICY NO_______________________

DENTAL INFORMATION

WHAT IS YOUR MAIN CONCERN FOR TODAY'S VISIT?____

ARE YOU EXPERIENCING ANY PAIN IN YOUR MOUTH AT THIS TIME? YES_____ NO_____

NAME AND PHONE NUMBER OF YOUR GENERAL DENTIST_____________________________________

CIRCLE ALL OF THE WORDS THAT APPLY TO YOU

BLEEDING GUMS SORE GUMS SENSITIVE GUMS GUM RECESSION INTERESTED IN IMPLANTS

ANY OTHER CONCERNS?____

HOW OFTEN DO YOU BRUSH YOUR TEETH?__________________ DO YOU USE DENTAL FLOSS_________

HOW OFTEN DO YOU GET YOUR TEETH CLEANED?_____________ DATE OF LAST CLEANING_________

DO YOU CLENCH/GRIND YOUR TEETH? YES_____ NO_____ IF SO, WHEN?_____________________

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HAVE YOU EVER BEEN TREATED FOR GUM DISEASE BEFORE? YES_____ NO_____

IF SO, WHEN?__________________________________ BY WHOM?______________________

PLEASE INDICATE WITH AN (X) ANY ALLERGIES OR REACTION TO THE FOLLOWING:

___LOCAL ANESTHETICS/NOVACAINE	___PHENERGAN	___SULFA	___OTHERS
___EPINEPHRINE	___VALIUM	___CODEINE	
___PENICILLIN	___MOTRIN	___DEMEROL	
___ERYTHROMYCIN	___ASPIRIN	___ALCOHOL	
___TETRACYCLINE	___TYLENOL	___LATEX	

DO YOU PRE-MEDICATE WITH ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? YES___ NO___

IF SO, FOR WHAT REASON?____

HAVE YOU HAD ANY JOINT REPLACEMENTS? YES___ NO___ WHEN?______________

HEART CONDITION? YES___ NO___ WHAT CONDITION?_________________________

ARE YOU CURRENTLY PREGNANT? YES___ NO___

DO YOU USE TOBACCO PRODUCTS? IF SO, WHAT KIND AND HOW MUCH?___________________________

YOUR FAMILY PHYSICIAN'S NAME:____________________________________PHONE NO.________________

ARE YOU CURRENTLY UNDER MEDICAL CARE BESIDES ANNUAL VISITS? YES___ NO___

NAME AND PHONE NO. OF YOUR CARDIOLOGIST/ANY OTHER SPECIALIST YOU SEE REGULARLY:

____

PLEASE INDICATE WITH AN (X) IF YOU CURRENTLY HAVE, OR HAVE EVER BEEN TREATED FOR:

_____HEART DISEASE	_____ASTHMA/LUNG DISEASE	_____GLAUCOMA
_____HEART MURMUR	_____KIDNEY/BLADDER PROBLEMS	_____A.I.D.S
_____VENERIAL DISEASE	_____RHEUMATIC FEVER	_____CANCER
_____BLEEDING PROBLEMS	_____ULCERS OR COLITIS	_____EPILEPSY
_____STROKE	_____LIVER PROBLEMS/HEPATITIS	_____PACEMAKER
_____CHEMOTHERAPY	_____DIABETES	_____JOINT REPLACEMENT
_____BLOOD THINNER	_____HIGH/LOW BLOOD PRESSURE	_____ANGINA
_____PSYCIATRIC TREATMENT	_____MITRAL VALVE PROLAPSE	

PLEASE LIST ANY MEDICATIONSYOU ARE CURRENTLYTAKING__________________________________

IS THERE ANY OTHER INFORMATION OR CONDITION CONCERNING YOUR MEDICAL OR DENTAL HISTORY NOT MENTIONED ABOVE? YES_____ NO_____

PLEASE EXPLAIN____

PATIENT SIGNATURE____ DATE_______________

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