Victoria Road Periodontal Associates

Name .... Birthdate D.........., M.........., Y.........., Mr. / Mrs. / Ms.

Mailing Address .... Home Phone..

City.. Postal Code.. Cellular Phone..

Employer.. Business Phone..

Name of Spouse (or Guardian).. Spouse's Birthdate D.........., M.........., Y..........,

Employer.. Business Phone..

Name of Dentist.. How Long..

Name of Physician.. How Long..

Reason for visit to this office..

Are you having pain in your mouth now?...................... If yes, Explain..

N.S. Health Card (MSI) No. |_|_|_|_| |_|_|_|_| |_|_|_|_|

Do you have Dental Insurance in Your Name? (y/n) ....

Insurance Company Name .... Group/Policy No. .... I.D. or Certificate No. ....

Do you have Dental Insurance in Your Spouses name? (y/n) .... or Parents name? (y/n) ....

Insurance Company Name .... Group/Policy No. .... I.D. or Certificate No. ....

HEALTH HISTORY

Periodontal disease is caused by a combination of many complex elements. Although some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

PLEASE ANSWER ALL QUESTIONS CAREFULLY

Yes No

1. Are you presently in good health? .... ❑ ❑
2. Date of last physical examination .... Are you being treated by a physician now? .... ❑ ❑

   Blood pressure .... Pulse ....
3. Please list your current drugs or medication ....

   ....

   ....

   ....
4. Have you had excessive bleeding requiring special treatment? .... ❑ ❑
5. Have you had surgery within the last five (5) years? .... ❑ ❑
6. Have you ever had radiation treatment? .... ❑ ❑
7. Have you ever had any of the following conditions? If Yes, please ☑

Heart disease/defects .... ❑	Respiratory Disorder .... ❑	Liver Disorder (Hepatitis A,B,C) .... ❑
Stroke .... ❑	Stomach Disorder .... ❑	Kidney Disorder .... ❑
Anemia .... ❑	Intestinal Disorder .... ❑	Diabetes .... ❑
Arthritis .... ❑	Blood Disease .... ❑	Hip/ Knee Replacement .... ❑
Asthma .... ❑	Are you HIV positive? .... ❑	Heart Valve replacement .... ❑

8. Please list other medical issues we should be aware of ....

   ....
9. Please list drug allergies such as Aspirin, Antibiotics or Anesthetics (e.g. Novocaine) ....
10. Please list any food allergies such as peanuts ....
11. Please list any allergies to materials such as Latex ....
12. If you smoke, how many packs per day? .... If you have quit smoking, how long ago?..
13. Have you ever had periodontal (gums) treatment? (y/n)............ Have you ever had orthodontic (braces) treatment or oral surgery? (y/n).............
14. Are you aware that you clench or grind your teeth? (y/n)............ Have you ever had treatment for your jaws? (y/n)............
15. Women: Are you pregnant? (y/n).......... Have you reached menopause? (y/n)..........
16. Is there anything else in your health history we should know? ....

Signature: .... Date: ....