Stanley I. Sehler DDS

DENTAL IMPLANTS
PERIODONTAL REGENERATION

CONFIDENTIAL HISTORY

Name_____ Age _____

Social Security # _____

Home/Cell Phone _____

Business Phone _____

Email Address _____

MEDICAL HISTORY

Date of last complete physical exam _____

Physician's Name _____

Physician's Address _____

Circle One

Are you taking any medications? Yes No
What? _____

_____

Has a doctor ever said your blood pressure was too high or too low? If yes, underline which one. Yes No

Have you ever been treated for heart disease? Yes No

Do you wear a pacemaker or have you had a heart valve replaced? Yes No

Have you ever been treated for or told you had Rheumatic Fever, Mitral Valve Prolapse or Heart Murmur? Yes No

Have you or any member of your family had diabetes? Yes No
Who? _____

Are you taking medication for Osteoporosis? (Fosamex, Actomel, Boniva, etc.) Yes No

Have you ever had anemia? Yes No

Has a doctor ever told you that you had a tumor or cancer? Yes No

Have you ever had to seek medical or dental treatment to stop bleeding following a cut or tooth extraction? Yes No

Are you allergic to any drugs? _____ Yes No

Have you ever had any ill effects from local anesthetics? Yes No

Have you had any operations? Yes No
Please list and give dates:

_____

_____

_____

Have you ever been treated for thyroid trouble? Yes No

Have you ever had seizures? Yes No

Do you smoke? Yes No

Does aspirin or codeine upset your stomach? Yes No

Have you ever had hepatitis? Yes No
What type? _____

Any other medical problems not mentioned previously? Yes No

_____

_____

Have you been tested for HIV (AIDS)? Yes No

Are you HIV positive? Yes No

FEMALE

Are you pregnant now? Yes No

Are you taking birth control pills? Yes No

Are you having symptoms of menopause? Yes No

_____

_____

_____

_____

_____

DENTAL HISTORY

Family dentist _____

Circle One

Are you experiencing any discomfort in your mouth at this time? Yes No
If yes, where? _____

Do you have bleeding gums after brushing? Yes No

Have you had gum boils or abscesses? Yes No

Have you ever had any teeth extracted because of periodontal disease (pyorrhea)? Yes No

Have you ever had surgical gum treatment? Yes No
If yes, when and by whom? _____

_____

Do you have any teeth which have shifted position recently? Yes No

Are aware of any loose teeth? Yes No

Do you frequently clench or grind teeth when tired, tense, or asleep? Yes No

Do you have teeth that are sensitive to hot, cold or sweets? Yes No

Have you ever had orthodontic treatment? (braces) Yes No

Have you been seeing a dentist on a routine basis? (once or twice a year) Yes No

Last time your teeth were cleaned? _____

Do you brush your teeth regularly? Yes No
How many times a day? _____

Other hygiene aids (circle all that apply):
dental floss rubber tip water pik electric toothbrush

_____

Other comments:

_____

_____

_____

Signature Date