EDWARD P. VAHEY, D.M.D., M.S.

PERIODONTICS * IMPLANTS * LASER SURGERY

NAME _____ MARITAL STATUS _____ SEX _____ DATE OF BIRTH _____ HT _____ WT _____

ADDRESS/STREET _____ CELL # _____ HOME # _____ BUSINESS # _____

CITY _____ ZIP CODE _____ E-MAIL _____ BEST WAY TO REACH YOU _____

DENTIST NAME ADDRESS CITY ZIP CODE HOW LONG HAVE YOU BEEN HIS/HER PATIENT?_____

HOW DID YOU LEARN ABOUT OUR PRACTICE? ◯ MY DENTIST ◯ FAMILY/FRIEND ◯ INTERNET ◯ OTHER: _____

REFERRED BY _____ REASON _____

PHYSICIAN NAME ADDRESS CITY ZIP CODE PHONE # _____

EMPLOYED BY _____ OCCUPATION _____

GENERAL HEALTH

	YES	NO
1. Are you in Good Health now?	_____	_____
2. Have you always been in Good Health?	_____	_____
3. Are you Pregnant?	_____	_____
4. Do you take any medication or pills of any kind (including vitamins)?	_____	_____
- If yes, please list your medications: _____		
5. Do you take Aspirin or baby Aspirin daily?	_____	_____
6. Do you have any Allergies to medications, drugs or foods?	_____	_____
- If yes, please list what medications, drugs or foods: _____		
7. Are you allergic to Latex?	_____	_____
8. Have you ever taken Fen Phen?	_____	_____
9. Has a doctor ever said you have Heart trouble or Angina Pectoris?	_____	_____
10. Have you ever had a Heart Attack or Stroke?	_____	_____
11. Do you have an Artificial Heart Valve?	_____	_____
12. Have you had any Joint Replacement (hip, knee etc.)?	_____	_____
13. Do you have a Heart Pacemaker?	_____	_____
14. Have you ever had Heart Surgery, Angioplasty or Angiogram procedures?	_____	_____
15. Have you ever been Hospitalized for any reason?	_____	_____
16. Do you smoke?	_____	_____
17. Have you ever smoked?	_____	_____

Do you have or have you ever had:	Check all that apply	Do you have or have you ever had:	Check all that apply
18. Rheumatic fever?	_____	29. Glaucoma?	_____
19. Anemia, Leukemia, or low platelets?	_____	30. Arthritis?	_____
20. Bleeding problems?	_____	31. HIV / AIDS?	_____
21. Epilepsy or convulsions?	_____	32. Stomach Ulcers?	_____
22. Tuberculosis?	_____	33. Heart Murmur?	_____
23. Asthma or Hay fever?	_____	34. Prostate trouble?	_____
24. Diabetes?	_____	35. Eczema, Hives or Rashes?	_____
25. Kidney trouble?	_____	36. Psychiatric treatment?	_____
26. Hepatitis, Liver trouble, or Jaundice?	_____	37. Cancer?	_____
27. Thyroid trouble or Goiter?	_____	38. Do you have any disease, condition/problem not listed?	
28. Syphilis?	_____	If yes, please list: _____	
27. Fainting or Dizziness?	_____	38. When was your last physical examination? Date_____	

GINGIVAL HEALTH

	YES	NO
1. Do your gums bleed now or have your gums ever bled before?	_____	_____
2. Do you sometimes get a Gingival Abscess (Gum Boil)?	_____	_____
3. Do your gums get sore, swell up, or otherwise feel strange?	_____	_____
4. Is your Mouth Dry?	_____	_____
5. Are any of your teeth loose?	_____	_____
6. Do you get food packed between your teeth?	_____	_____
7. Have you ever experienced any unfavorable reaction from dental treatment?	_____	_____
8. Are you missing any teeth? _____ Reason: ◯ Decay ◯ Gum Disease ◯ Other	_____	_____
9. Do you clench or grind your teeth (possibly during sleep)?	_____	_____
10. Do you have any Clicking, Popping or pain in your jaw?	_____	_____
11. Have you ever had gum treatment (Root Planing or Surgery)?	_____	_____
12. Have you ever had Orthodontic Treatment - Braces, Invisilign etc…..?	_____	_____
13. Do you regularly use anything else to clean your teeth?	_____	_____

14. When did you have your teeth cleaned prior to this appointment? _____ How long before that? _____
15. How often do you brush your teeth? _____
16. Do you use: Hand toothbrush ◯ Electric ◯ (which brand?) _____

**** On a scale of 1-10, How bad do you feel your gum disease is? _____**

1= Perfect Periodontal Health (No problems or bleeding) and 10= Severe disease (bleeding, bone loss, and will likely lose some teeth).

Signature of Patient, Parent or Guardian _____ **Date** _____