Patient Questionnaire (Periodontal)

Form PERIOQ

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

REFERRED BY: _____

Dental Concerns

Gum Health

Y☐ N☐ Bleeding
Y☐ N☐ Sore or sensitive
Y☐ N☐ Swollen gums

Other

Y☐ N☐ Dry mouth
Y☐ N☐ Altered taste
Y☐ N☐ Mouth sores
Y☐ N☐ Mouth lesions
Y☐ N☐ Mouth odor
Y☐ N☐ Tooth grinding

Y☐ N☐ Are you here only for a "Periodic Examination"?

Other concerns or reasons for visit: _____

Allergens

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Sedatives
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tetracycline

Other allergens

_____

_____

Patient Signature _____ Date _____