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Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

Please fill in questions or circle yes or no, whichever applies.

PRESENT HEALTH:

1. How would you describe your present health? Excellent Good Fair Poor
2. Has there been any change in your health in the past year? Yes No
3. Are you now under the care of a physician? Yes No
4. Date of last physical exam? _____
5. What medications are you presently taking? _____

(Please write in the names of pills you are still taking as written on the drug bottles)

PAST MEDICAL HISTORY:

6. Have you been a patient in a hospital during the past 5 years? Yes No
7. Have you had any serious illness or operation? Yes No
If so, what and when? _____
8. Have you ever taken Cortisones? Yes No

CARDIOVASCULAR:

9. Have you ever had any heart trouble? Murmurs? Stroke? Chest Pain? Yes No
10. Have you ever taken anticoagulants (blood thinners)? Yes No
11. Has your blood pressure ever been too high or too low? Yes No
12. Have you ever had Rheumatic fever or Rheumatic heart disease? Saint Vitus' dance? Yes No
13. Do your ankles often become swollen? Yes No
14. How many pillows do you sleep on? _____
15. Are you subject to fainting spells? Yes No
16. Do you suffer from angina? Yes No

BLOOD

17. Have you ever had anemia? Yes No
18. Have you ever had abnormal bleeding problems after a cut or tooth extraction? Yes No
19. Do you bruise easily? Yes No Yes No
20. Have you ever had severe or spontaneous nose bleeds? Yes No

RESPIRATORY:

21. Do you ever become short of breath? Yes No
22. When was your last chest X-Ray? _____
23. Do you have frequent colds that keep you out of work? Yes No
24. Have you ever had tuberculosis or a persistent cough? Bronchitis? Yes No
25. Do you breathe primarily through your mouth? Yes No
26. Do you have asthma or hay fever? Yes No

G.I. AND G.U.

27. Have you ever had yellow jaundice or hepatitis? Yes No
28. Have you ever had any liver or gall bladder problems? Yes No
29. Are you on any special diet? Yes No
30. Have you ever had any gastrointestinal disorders? Yes No
31. Have you any kidney or bladder difficulty? Painful or frequent urination? Blood in urine? Yes No
32. Have you ever had syphilis or gonorrhea? VD? Yes No
33. Do you have an ulcer? Yes No

FEMALES:

34. Are you pregnant? Yes No
35. Do you have any problems associated with your menstrual period? Yes No
36. Have you undergone, or are you presently undergoing, menopause? Yes No
37. Have you ever taken birth control medication? Yes No

ENDOCRINE:

38. Do you or any member of your family have diabetes? Yes No
39. Do you heal normally? Yes No Slowly? Yes No
40. Have you ever received treatment for any endocrine or glandular disorder? Thyroid? Yes No

NERVOUS:

41. Do you suffer frequent or severe headaches? Yes No
42. Have you ever had severe pains of head or face? Yes No
43. Are you under tension? Yes No
44. Do you consider yourself excessively nervous? Yes No
45. Have you ever had epilepsy or convulsions? Dizzy spells? Blackouts? Yes No

ALLERGIES:

46. Are you sensitive or allergic to any particular medicines? Yes No
(Aspirin, Penicillin, Novocain) _____
47. Have you ever had hives or a rash? Yes No
48. Do you have an allergy? Yes No

OTHER: Are there any pills or medicines you must not take?

49. Have you ever been treated for any skin disease? Yes No
50. Have you ever received X-Ray or Radioactive Isotope treatment? Yes No
51. Has a doctor ever told you that you had a tumor or cancer? Yes No
52. Have you ever had Glaucoma, Arthritis, Pneumonia? Yes No
53. Have you recently gained or lost weight? Yes No
54. Do you smoke? Yes No Packs per day _____
55. Do you drink alcohol on a daily basis? Yes No
56. What is your weight? _____ Height? _____