Tpi Dental | Trinidad Periodontal and Implant Centre

Gum Treatments • Dental Implants • Cosmetic Dentistry

Date _____

Name	Date of Birth
Occupation	Telephone (Home) (Mobile) (Work)
Last Medical Examination Blood T aken?	Findings / Physician(s) Name & T elephone
General Dentist	Have Family or Friends Been T reated Here?

PRESENT DENTAL COMPLAINTS

DENTAL HISTORY

	Yes	No
Do you fear dental treatment		
Have you ever been tr eated for periodontal disease		
Do your gums bleed		
Do you have difficulty chewing your food		
Do you grind or clench your teeth		
Do you have a bite guard/splint		
Are spaces developing between your teeth		
Have you noticed your bite changing		
Are you aware of breath odor		
Do you have frequent cold/canker sores		
Do you have pain in the jaw joints (TMJ)		
Have you ever had orthodontic treatment to straighten your teeth		
Does food wedge between your teeth		
Has any member of your family lost all their teeth		
Would you be tremendously disturbed to lose all of your teeth		
Are you having pain or discomfort at this time		
Do you have a strong gag reflex		

When was your last dental cleaning _____

How often have your teeth been cleaned in the past 3 years _____

How long have you been a patient of your present dentist _____

How long have you known about your gum condition _____

Are your teeth sensitive to: Hot _____ Cold _____ Sweet _____

Are you satisfied with the appearance of your teeth Yes ___ No ___

If no, why not _____

How would you rate your past dental care _____

Do you desire nitrous oxide during treatment _____

Are you available on short notice for appointments Yes ___ No ___

Please check any of the following items used in mouth care:

Hand toothbrush _____ Type / Frequency _____

Electric toothbrush _____ Type / Frequency _____

Dental floss / Frequency _____

Proxabrush _____

Toothpicks _____

Water spray device _____

Toothpaste _____ Type _____

Mouthwash _____ Type _____

Other _____

DENTAL HISTORY NOTES

TURN OVER →

B.P.	Pulse

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
Heart attack or stroke, Heart disease _____	☐	☐
Heart murmur or valve problem	☐	☐
Artificial heart valve	☐	☐
Angina pectoris (Chest pain)	☐	☐
Shortness of breath	☐	☐
Swelling in ankles	☐	☐
High blood pressure	☐	☐
Heart pacemaker	☐	☐
Abnormal bleeding problems or blood disorder	☐	☐
Diabetes	☐	☐
Or family history of diabetes	☐	☐
Hepatitis or liver disease	☐	☐
Thyroid or parathyroid disease	☐	☐
Stomach or duodenal ulcers	☐	☐
Gastro-esophageal reflux (GERD)	☐	☐
Kidney disease	☐	☐
Prostate issues	☐	☐
Seizure Disorder (Epilepsy)	☐	☐
Glaucoma	☐	☐
Osteoporosis or osteopenia	☐	☐
Medication for osteoporosis/osteopenia _____	☐	☐
Arthritis	☐	☐
Osteoarthritis or Rheumatoid (circle one)	☐	☐
Artificial joint replacement	☐	☐
Orthopedic screws, pins, etc.	☐	☐
Autoimmune Condition	☐	☐
Emphysema or chronic bronchitis	☐	☐
Lung disease	☐	☐
Tuberculosis	☐	☐
Sleep Apnea / Device (List) _____	☐	☐
Asthma	☐	☐
Drug reaction to penicillin, erythromycin, clindamycin, tetracycline, codeine, Demerol, Percodan, Percocet, aspirin, ibuprofen, nitrous oxide, other _____	☐	☐

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
HIV or AIDS	☐	☐
Cold sores or oral Herpes	☐	☐
Cancer or abnormal growth	☐	☐
Radiation or chemotherapy	☐	☐
Anticoagulants (blood thinners)	☐	☐
Alcoholism	☐	☐
Drug addiction	☐	☐
Eating disorder (anorexia, bulimia, etc.)	☐	☐
Depression	☐	☐
Any serious illness, disease, condition, not listed: _____ _____ _____	☐	☐

ARE YOU:		
Claustrophobic	☐	☐
Under unusual stress	☐	☐
Taking medication for anxiety/depression	☐	☐
Taking sleeping medication	☐	☐
Undergoing psychological treatment	☐	☐
Do you wear contact lenses	☐	☐
Do you currently use tobacco products	☐	☐
Type _____ Amount _____	☐	☐
Have you used tobacco products in the past	☐	☐
Do you use Cannabis or THC products	☐	☐
Type _____ Amount _____	☐	☐

IF FEMALE, are you now (please check if yes)

Pregnant ☐ Nursing ☐
Anticipate becoming pregnant ☐
Presently in (or post) menopause ☐
Taking oral contraceptives ☐
Hormone Replacement Therapy ☐

LIST CURRENT MEDICATIONS, SUPPLEMENTS & VITAMINS (ATTACH A LIST IF NECESSARY):

Prescription: _____

_____

_____

Over-the-Counter: _____

_____

PAST SURGERIES OR HOSPITALIZATIONS: _____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor or his/her staff at the next appointment without fail.

DATE: _____ PATIENT'S SIGNATURE _____
(Guardian/Parent if minor)