LARRY A. JOHNSON, DDS, PC
Practice Limited to Periodontics

Name:_____Soc.Sec#_____DOB_____

Address:_____City_____Zip_____

Home Phone#_____ Work#_____ _____Cell_____

Place of Employment_____ _____Occupation_____
Business Address_____

Name of Spouse or Nearest Relative_____
Spouses Employer_____
Business Address_____

Name of friend or relative at a different address_____
Their phone#_____

Name of Dentist_____
Name of Physician_____

Whom may we thank for referring you to the office?_____

Insurance Carrier:

Dental Primary_____Policy#_____Carriers name_____
Secondary_____Policy#_____Carriers name_____
Medical Ins._____Policy#_____Carriers name_____

Any additional information you feel we should know:_____
_____

What name would you prefer our staff use when addressing you?_____

LARRY A. JOHNSON, D.D.S., P.C.

PRACTICE LIMITED TO PERIODONTICS

ADULT EXAMINATION and HEALTH HISTORY QUESTIONNAIRE

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.

Name _____ Address _____

For the following questions please circle yes or no whichever applies. Your answers are for our records only and will be confidential.

1. Are you in good health ..... Yes No
2. Date of last physical exam _____ Are you being treated by a physician? ..... Yes No
3. Have you ever had excessive bleeding requiring special treatment ..... Yes No

4. Have you had a blood transfusion in the last five (5) years ..... Yes No
5. Have you had surgery in the last five (5) years ..... Yes No
   If yes, for what _____
6. Have you had any of the following conditions? If yes, state when.

Rheumatic fever	Yes	No	Hepatitis (liver disorder)	Yes	No
Heart murmur	Yes	No	Kidney Disorder	Yes	No
Heart disease	Yes	No	Respiratory Disorder (tuberculosis)	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
High or low blood pressure	Yes	No	Asthma	Yes	No
Blood disease	Yes	No	Venereal Disease	Yes	No
Anemia	Yes	No	Thyroid Disorder	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Cancer	Yes	No	Epilepsy	Yes	No
Stomach Trouble	Yes	No	Are you HIV Positive	Yes	No

7. Has anyone in your family had diabetes?.....If yes who ..... Yes No
8. Are you allergic to any of the following drugs?

Local Anesthesia (novacaine)	Yes	No	Barbituates, Sedatives	Yes	No
Penicillin	Yes	No	Sleeping pills	Yes	No
Other antibiotics	Yes	No	Codeine	Yes	No
Aspirin	Yes	No	Any other drugs	Yes	No

9. Have you ever had X-Ray treatment for a tumor or skin disease? ..... Yes No
10. Have you ever been treated for any type of skin disease? ..... Yes No
11. Are your joints ever painful or swollen? ..... Yes No
12. Do you get out of breath easily? ..... Yes No
13. Do you smoke? If yes, how many packs per day? ..... Yes No
14. Have you ever had periodontal treatment (treatment of the gums)? ..... Yes No
15. Have you ever had Orthodontic Treatment (braces)? ..... Yes No
16. Have you ever had Endodontic Treatment (Root canal)? ..... Yes No
17. Are you having pain in your mouth now? ..... Yes No
    If yes explain _____
18. Do you have any artifical hip or joint replacements? ..... Yes No
19. Please list any medications you are taking, the dosage, the reason and how long you have been taking them? _____
    _____
20. Have you ever been told you needed antibiotic prophylaxis for dental procedures? ..... Yes No
21. Do you have any disease, condition, or problem not listed above that I should know about? Have you ever been exposed to HIV virus (including AIDS, ARC, or AIDS related disorders). If yes, please explain. Yes No

    _____

Women: Hormones do affect the oral tissue which makes the following questions important.

22. Are you pregnant? ..... Yes No
23. Have you reached menopause? ..... Yes No
24. Do you take birth control pills or other oral contraceptives? ..... Yes No
25. Do you take any prescribed hormonal supplements? ..... Yes No

I certify that I have read and understand the above health history.

Patients Signature _____ Date _____

(parent or guardian if under 18)