DANIEL M. STEWART, D.D.S.

PERIODONTAL EXAMINATION RECORD

This information will help insure a thorough diagnosis and an optimum treatment plan. All information will be held in strict confidence.

Name_____ Date of Birth_____ Age_____ Date_____
Residence Address_____ City_____ Zip_____ Ph.(H)_____
Cell Phone_____ Voice Mail_____ E-Mail_____
Business Name_____ Phone (B)_____
Occupation_____ Spouse Name_____ Spouse Employer_____
Dentist_____ Address_____ How Long?_____
Physician_____ Address_____ Last Exam_____
Person responsible for account if other than yourself_____ Ph._____
Whom may we thank for referring you?_____
Nearest relative other than spouse_____ Ph._____

MEDICAL HISTORY

Height_____ Weight_____

Do you now or have you ever had	YES	NO
Epilepsy, convulsions or seizures _____	❑	❑
Hepatitis, jaundice or liver disease _____	❑	❑
Rheumatic fever _____	❑	❑
Any form of venereal disease _____	❑	❑
Heart murmur or valvular disease _____	❑	❑
Tuberculosis or emphysema _____	❑	❑
HIV, AIDS _____	❑	❑
Diabetes, you or immediate family _____	❑	❑
Asthma or persistent bronchitis _____	❑	❑
Heart trouble or stroke _____	❑	❑
High/low blood pressure _____	❑	❑
Chest pains, shortness of breath _____	❑	❑
Glaucoma, eye disorder _____	❑	❑
Thyroid or parathyroid disorders _____	❑	❑
Ulcers or stomach problems _____	❑	❑
X-ray treatments for tumors, etc. _____	❑	❑
Bleeding disorder, anemia _____	❑	❑
Osteoporosis, low bone density _____	❑	❑
Cancer, tumors, leukemia _____	❑	❑
Frequent headaches _____	❑	❑
Packs of cigarettes/day 0 ½ 1 1½ 2 3		
Alcoholic drinks/day 0 1 2 3 4 5		

	YES	NO
Allergy to food, medicine, other _____	❑	❑
Reaction on contact with rubber, latex or elastic? _____	❑	❑
Reaction to any medication _____	❑	❑
Any serious illness not listed _____	❑	❑
Are you under the care of a physician? _____	❑	❑
Why? _____		
Are you taking any medicine now? _____	❑	❑
Within last year? _____	❑	❑
List: _____		
Ever taken medicine for bone density? example: Fosomax, Actonel, etc. _____	❑	❑
Ever been told to take medicine before dental appointments? _____	❑	❑
Have you ever had major surgery? _____	❑	❑
List: _____		
Are you ever slow to heal? _____	❑	❑
Have you ever bled an unusually long time after cuts or extractions? _____	❑	❑
For Females: Might you be pregnant? _____	❑	❑
Taking birth control medication? _____	❑	❑

DENTAL HISTORY

What brings you to our office? _____
Describe any discomfort or concern with your mouth or teeth
_____
Previous periodontal care? _____ Please summarize: _____
How important is it to you to keep your teeth? _____
Do you ever clench your teeth? _____ Might you ever grind or clench your teeth while sleeping? _____
How long since last cleaning? _____ Frequency of brushing: _____ Frequency of flossing:_____
List any complications you have had during or after dental care: _____
How can we help you feel comfortable? _____
Please add anything you feel is important: _____

Patient or Parent/Guardian signature:_____ Date_____ Reviewed_____ Date_____
COMMENTS_____
_____
_____

Print Form **Submit Form**