MICHAEL L. COHEN, D.D.S.
SPECIALIST IN PERIODONTICS INCLUDING IMPLANTS

NOTE TO PATIENT: These questions are for your benefit and the answers are confidential. This information will assist us in your diagnosis and treatment.

Name: _____ Occupation: _____

Street: _____ Employer: _____

City: _____ State: _____ Zip: _____ Street: _____

County: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Dental Insurance Carrier: _____

Work Phone: _____ Group Number: _____

Birth Date: _____ ID Number: _____

Height: _____ Weight: _____ Spouse's Name: _____

Referred by: _____ Spouse's Occupation: _____

Dentist: _____ Preferred Method of Payment:

Physician: _____ VISA MASTERCARD CHECK CASH

MEDICAL HISTORY

Check any of the following which apply to you:

- ☐ Heart Trouble/Disease
- ☐ Congenital Heart Problems
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Rheumatic Fever
- ☐ Cardiac Pacemaker
- ☐ Heart Valve Prosthesis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Joint Replacement Prosthesis
- ☐ Swelling of Joints
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Cancer
- ☐ Glaucoma
- ☐ Sinus Trouble
- ☐ Persistent Cough
- ☐ Asthma
- ☐ HIV Infection/AIDS
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Epilepsy
- ☐ Psychiatric Care
- ☐ Child Births
- ☐ Blood Transfusion
- ☐ Venereal Disease/Other Sexually Transmitted Disease

1. Have you had a recent complete physical examination? _____ When? _____
2. Has there been any change in your general health in the last year? _____ Explain: _____
3. Have you been under a doctor's care, been hospitalized or seriously ill during the past two years? _____ Explain: _____
4. Do you take any medications or drugs, including aspirin, vitamins, hormones, antacids, steroids or birth control pills, presently or within the last year? _____

Drug	Dose & Frequency

5. Are you allergic or have you experienced an unusual reaction to drugs? _____
6. Have you experienced any other allergic reactions? _____
7. Have you ever experienced excessive bleeding that required special treatment? _____
8. Is there a history of diabetes in your immediate family? _____
9. Are you required to restrict your diet, work or activities in any way? _____
10. Do you smoke cigarettes? _____ Cigars? _____ Pipe? _____ How many per day? _____ For how long? _____
11. Have you ever been treated for a growth or tumor in any part of your body? _____
12. Are you under any stress on a daily basis, or has your daily stress increased? _____

13. Do you have frequent headaches?_____

14. Do you have any disease, condition or problem not listed above that you feel we should know about? If so, please explain: _____

WOMEN:

15. Are you pregnant?_____ Due Date?_____ Is your menstrual cycle regular? _____

16. Are you having any menopause symptoms?_____ Please Explain: _____

_____

DENTAL HEALTH HISTORY

Check any of the following which you may have had or experienced:

- ☐ Injury to Face or Jaw
- ☐ Slow Healing Mouth Sores
- ☐ Fever Blisters
- ☐ Mouth Ulcers
- ☐ Swollen Gums
- ☐ Bleeding Gums
- ☐ Receding Gums
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Mouth Odor
- ☐ Bad Taste in Mouth
- ☐ Gum Abcesses
- ☐ Loose Teeth
- ☐ Teeth Changing Positions
- ☐ Change in Bite
- ☐ Tired Jaw or Sore Muscles
- ☐ Aches in Jaw Joint
- ☐ Aching, Clicking, Popping in Jaw Joint

Which of the following do you use on a daily basis?

- ☐ Toothbrush
- ☐ Toothpicks
- ☐ Floss
- ☐ End-Tuft Brush
- ☐ Proxabrush
- ☐ Stimudents
- ☐ Mouthwash (Type) _____
- ☐ Fluoride Rinse
- ☐ Other: _____

1. If you are currently experiencing pain in your mouth, where is it located? _____
2. How did it come to your attention that you have a periodontal problem? _____
3. Do you feel strongly about keeping your teeth for the rest of your life?_____
4. Are you happy with the appearance of your teeth? _____
5. Have you had orthodontic therapy (braces)?_____ Type:_____ When? _____
6. Have you had previous periodontal (gum) treatment? _____
7. Have you had oral surgery?_____ Type:_____ When? _____
8. Have you had crown and/or bridgework?_____ When?_____
9. Have you ever worn a bite guard, bite plane or night guard?_____ When? _____
10. Have you noticed any change in the position of your teeth?_____ When?_____
11. Do you have any difficulty in chewing?_____ Explain:_____
12. Is it difficult to open your mouth wide? _____
13. Are you worried about receiving dental treatment?_____ If so, what is your main concern? _____

_____

Present Dentist: _____How long?_____

Last Dental Treatment: _____For What?_____

Last Cleaning:_____ Last X-rays: _____

Pattern of Dental Care: ☐ Regular ☐ Sporadic ☐ Infrequent

Signature:_____ Date:_____

Dunmire Printing Company • (814) 944-7733