Martin Periodontics
L.S. Martin, D.D.S., M.S.
PRACTICE LIMITED TO PERIODONTICS,
ORAL DIAGNOSIS AND IMPLANTS

SS # (self)_____

SS # (spouse) _____

LAST NAME	FIRST NAME	MI	BIRTH DATE (mo/day/yr)	HEIGHT	WEIGHT	MARITAL STATUS

RESIDENCE ADDRESS	CITY	STATE	ZIP	RESIDENCE PHONE (self)

BUSINESS NAME	ADDRESS	CITY	STATE	ZIP	OCCUPATION	BUSINESS PHONE (self)

NAME OF HUSBAND, WIFE OR PARENT	DRIVER LICENSE #	CELL PHONE (self)

REFERRED BY	NAME OF PHYSICIAN	PHYSICIAN'S TELEPHONE	E-MAIL (self)

	GENERAL * Don't Know	Circle One		
1)	Has there been any change in your general health during the last year?	Yes	No	DK*
2)	Have you been examined by your physician in the last year?	Yes	No	DK
3)	Are you receiving any treatment by any doctor now?	Yes	No	DK
4)	Are you taking any medicines now?	Yes	No	DK
5)	Have you ever had an operation?	Yes	No	DK
6)	Have you ever had a serious illness?	Yes	No	DK
7)	Have you ever been hospitalized?	Yes	No	DK
8)	Has a dentist or physician ever told you that you had a tumor or cancer?	Yes	No	DK
9)	Have you ever had x-ray treatments (cobalt)?	Yes	No	DK
10)	Have you had rheumatic fever, growing pains, or twitching of the limbs?	Yes	No	DK
11)	Have you had a stroke (apoplexy, CVA)?	Yes	No	DK
12)	Have you ever had excessive bleeding following extraction of teeth or from a cut?	Yes	No	DK
13)	Are you sensitive to any medicine (Aspirin-Penicillin)?	Yes	No	DK
14)	Have you ever had an anesthetic?	Yes	No	DK
15)	Have you ever been told not to take novocaine?	Yes	No	DK
16)	Do you suffer badly from frequent severe headaches?	Yes	No	DK
17)	Do you have spells of dizziness?	Yes	No	DK
18)	Have you fainted more than twice in your life?	Yes	No	DK
19)	Have you ever had severe pains of the face or head?	Yes	No	DK
20)	Have you ever been treated for eye trouble other than corrective glasses?	Yes	No	DK
21)	Have you ever been treated for ear trouble?	Yes	No	DK
22)	Do you have hay fever? Sinus trouble?	Yes	No	DK
23)	Do you have AIDS? Have you tested HIV positive?	Yes	No	DK
24)	Have you at times had bad nose bleeds?	Yes	No	DK
25)	Do you have frequent sore throats?	Yes	No	DK
	CARDIOVASCULAR			
26)	Has a physician ever said you had heart trouble?	Yes	No	DK
27)	Have you had rheumatic heart disease or heart murmur?	Yes	No	DK
28)	Have you ever had a heart attack?	Yes	No	DK
29)	Has a physician ever said your blood pressure was too high or too low?	Yes	No	DK
30)	Do you get out of breath easily?	Yes	No	DK
31)	Are your ankles often badly swollen?	Yes	No	DK
32)	Do you bruise easily?	Yes	No	DK
	GASTRO-INTESTINAL			
33)	Do you suffer from stomach trouble?	Yes	No	DK
34)	Have you ever had liver trouble? Hepatitis?	Yes	No	DK
35)	Do you have frequent diarrhea?	Yes	No	DK
36)	Has a physician ever told you that you had ulcers?	Yes	No	DK
37)	Are there any foods you cannot eat?	Yes	No	DK
38)	Have you gained or lost weight recently?	Yes	No	DK
39)	Have you ever been jaundiced?	Yes	No	DK

Patient's Signature_____ Date_____

Above Signature May Be Used For Insurance Purposes (as signature on file)

	RESPIRATORY	Circle One		
40)	Have you ever coughed up blood?	Yes	No	DK*
41)	Do you have asthma?	Yes	No	DK
42)	Have you ever had tuberculosis?	Yes	No	DK
43)	Have you ever lived with anyone who had TB?	Yes	No	DK
	GENITO-URINARY			
44)	Are you thirsty much of the time?	Yes	No	DK
45)	Did a physician ever say that you had kidney or bladder trouble?	Yes	No	DK
46)	Do you have to get up every night to urinate?	Yes	No	DK
47)	Have you ever had a venereal disease?	Yes	No	DK
	FEMALE			
48)	Have you ever been pregnant? Number of times _____	Yes	No	DK
49)	Is your menstrual cycle irregular?	Yes	No	DK
50)	Have you reached the menopause? (Change of life)	Yes	No	DK
	ENDOCRINE SYSTEM			
51)	Have you ever had diabetes?	Yes	No	DK
52)	Has a member of your family had diabetes?	Yes	No	DK
53)	Have you ever taken thyroid tablets?	Yes	No	DK
54)	Do you get tired easily?	Yes	No	DK
	NERVOUS SYSTEM			
55)	Have you ever had a nervous breakdown?	Yes	No	DK
56)	Has a physician ever told you that you had epilepsy?	Yes	No	DK
57)	Do you consider yourself a nervous person?	Yes	No	DK
	SKIN			
58)	Have you ever been treated for a skin disease?	Yes	No	DK
59)	Do cuts on your skin usually stay open a long time?	Yes	No	DK
60)	Have you ever had hives or skin rash?	Yes	No	DK
	BONES AND JOINTS			
61)	Are your joints often painfully swollen?	Yes	No	DK
62)	Have you ever had more than one fracture?	Yes	No	DK
63)	Have you ever had more than one dislocation?	Yes	No	DK
64)	Do you have arthritis or rheumatism?	Yes	No	DK
	DENTAL			
65)	Do your gums bleed when you brush your teeth?	Yes	No	DK
66)	Have you ever had gum treatments?	Yes	No	DK
67)	Have you ever had an acute sore mouth?	Yes	No	DK
68)	Do your teeth ever feel sore when you bite on them?	Yes	No	DK
69)	Do any teeth feel high or long when you bite on them?	Yes	No	DK
70)	Do your jaws feel tired at the end of the day?	Yes	No	DK
71)	Do your jaws feel tired when you awaken in the morning?	Yes	No	DK
72)	Do you think your teeth are moving or drifting?	Yes	No	DK
73)	Do you grind or clench your teeth when you are nervous or while sleeping?	Yes	No	KD
74)	Do your jaws crackle or pop when you yawn or open your mouth?	Yes	No	KD
75)	Do you feel an attempt to save your teeth is a waste of time?	Yes	No	DK

Chief Complaint:_____

Medical Summary: ❑ **Non-Contributory** ❑ **Significant** _____

Medications: 1_____ 4_____

2_____ 5_____

3_____ 6_____

Patient's Name_____