



BPDI HEALTH QUESTIONNAIRE

Your Full Name: Mr., Ms., Mrs., Miss, Dr.. _____

Date of Birth _____ Single Married Divorced Widowed

Home Address _____ Home phone _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Business phone _____

City _____ State _____ Zip _____

Social Security # _____ Dental Insurance _____

Email _____ Cell phone _____

Family Dentist's Name _____ How long? _____

Physician's Name _____ How long? _____

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

Please answer the following accurately and completely. The diagnosis and treatment of your condition depends on the identification of every possible contributing factor. Although some of the questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health.

	YES	NO
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any changes in your general health?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you gained or lost weight in recent months? If so, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious illnesses or operations? _____	<input type="checkbox"/>	<input type="checkbox"/>
Please explain: _____		
Date of last physical exam? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for what? _____		
Are you presently taking any drugs or medications?	<input type="checkbox"/>	<input type="checkbox"/>
List: _____		
Are you taking or have you ever taken bisphosphonate medications?	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any of the following conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice or liver involvement |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Tuberculosis or lung disease |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Asthma/Hay fever | <input type="checkbox"/> AIDS, ARC or HIV+ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse |

Are you unable to take any of the following drugs?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Local anesthesia ("Novocaine") | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Demerol |
| <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> Other Drugs |
| <input type="checkbox"/> Aspirin | (please list) _____ |

	YES	NO
Have you ever had abnormal bleeding following dental extractions, surgery, or a cut?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had radiation treatment for a tumor or skin disease?	<input type="checkbox"/>	<input type="checkbox"/>
Has any blood relative ever had diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic sores or boils of any kind on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get short of breath after climbing one flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>
Do your ankles swell during the day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get pains in your chest or over your heart?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been exposed to the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever used intravenous drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have swollen lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
	How much? _____	How much? _____

WOMEN ONLY

	YES	NO
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormones?	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HISTORY

	YES	NO
Please describe your present dental problem? _____		

Have you ever had a serious problem associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any discomfort or pain?	<input type="checkbox"/>	<input type="checkbox"/>
If so, where? _____		
Are your teeth sensitive to cold, hot, or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ache when you awaken in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any loose or shifting teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you chew satisfactorily?	<input type="checkbox"/>	<input type="checkbox"/>
When you chew, do you have cracking, popping, or pain in the jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>
Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had orthodontic therapy (braces)?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any mouth odor or bad taste?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have fever blisters or cold sores on your lips?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had prior periodontal therapy?	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature

Date

Doctor's Signature

Date



**BOSTON PERIODONTICS
 & DENTAL IMPLANTS**

Marc L. Nevins, D.M.D., M.M.Sc., P.C.