

# Patient Medical History

Patient Name \_\_\_\_\_  
 Patient Date of Birth \_\_\_\_\_

**PAUL R. GIBBS, D.D.S., M.S.**  
**PERIODONTICS**  
 Comprehensive Periodontal Care and Implants

What is your chief dental complaint? \_\_\_\_\_

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

1. Are you under medical treatment now?.....  Yes  No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs?  Yes  No  
 If yes, please explain: \_\_\_\_\_
3. Are you taking any medication(s) including non-prescription medicine?.....  Yes  No  
 If yes, what medication(s) are you taking? \_\_\_\_\_
4. Have you ever taken Fen-Phen/Redux?.....  Yes  No
5. Do you use tobacco?.....  Yes  No
6. Do you use controlled substances?.....  Yes  No
7. Are you under psychiatric care?.....  Yes  No

8. Are you allergic to or have you had any reactions to the following?  Yes  No
  - Local Anesthetics (e.g. Novocain).....  Yes  No
  - Penicillin or any other Antibiotics.....  Yes  No
  - Sulfa Drugs.....  Yes  No
  - Barbiturates.....  Yes  No
  - Sedatives.....  Yes  No
  - Iodine.....  Yes  No
  - Aspirin.....  Yes  No
  - Any Metals (e.g. nickel, mercury, etc.).....  Yes  No
  - Latex Rubber.....  Yes  No
  - Other / Foods (pls. list): \_\_\_\_\_  Yes  No
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?.....  Yes  No

Do you have or have you had any of the following?

- |                                       | Yes                      | No                       |
|---------------------------------------|--------------------------|--------------------------|
| Chemotherapy / Radiation Treatment... | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease.....                    | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                   | Yes                      | No                       |
|-----------------------------------|--------------------------|--------------------------|
| Cardiac Pacemaker.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer / Tumors.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement or Implant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis / Jaundice.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles / Ulcers.....    | <input type="checkbox"/> | <input type="checkbox"/> |

- |                            | Yes                      | No                       |
|----------------------------|--------------------------|--------------------------|
| Chest Pains.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Winded.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever / Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Loss.....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other.....                 | <input type="checkbox"/> | <input type="checkbox"/> |

# Patient Dental History

Women Only:

- a) Are you pregnant or possibly pregnant?.....  Yes  No
- b) Are you nursing?.....  Yes  No
- c) Are you taking contraceptives?.....  Yes  No

Name of Referring Dentist and Location: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?.....                  | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?.....          | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?.....        | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past?.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?.....                          | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions?.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth?.....           | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?.....                    | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? |                          |                          | If yes, date of placement _____  |                          |                          |
| Clicking.....   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face).....                                    | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | 17. Does your mouth frequently become dry?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing.....  | <input type="checkbox"/> | <input type="checkbox"/> | 18. Any serious trouble associated with previous dental care?.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

# Authorization and Release

I certify that I have read and answered the above to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have reviewed or declined to review the privacy policy of this office.

Print Name \_\_\_\_\_ Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Copies of our Privacy Policy are located at the front desk and on the clipboards.

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