DAVID W. COMPTON, D.M.D., M.S., P.C.
SPECIALIST IN PERIODONTICS

PATIENT HEALTH HISTORY

Name: _____

HEALTH HISTORY

1. Do you consider your general health to be ☐ good ☐ fair ☐ poor.
2. Date of last physical exam: _____ Findings: _____
3. Are you currently being treated by a physician? ☐ Yes ☐ No
4. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No
   If so, what and how much?_____
5. Are you taking any drugs or medications including herbal or vitamin supplements?
   ☐ Yes ☐ No If so, please list: _____
6. Have you reacted adversely to any drugs or medications? ☐ Yes ☐ No
   If so, please list: _____
7. Do you have any allergies to foods, dust, pollens, latex, etc.? ☐ Yes ☐ No
   If so, please list: _____
8. Have you had any abnormal bleeding associated with extractions, injury, surgery, or menstruation? ☐ Yes ☐ No
   Have you ever had any facial trauma? ☐ Yes ☐ No
9. Have you ever had surgery? ☐ Yes ☐ No
10. Do you have heart trouble? ☐ Yes ☐ No
    ☐ Rheumatic Heart Condition ☐ High Blood Pressure
    ☐ Heart Attack ☐ Heart Valve ☐ Heart Murmur ☐ Other _____
11. Have you ever had, or do you now have, any of the following? ☐ Yes ☐ No

☐ Blood Disorder	☐ Prosthetic Joint	☐ Tuberculosis
☐ Anemia	☐ Dry Mouth	☐ Asthma
☐ Stroke	☐ Thyroid Disorder	☐ Hepatitis
☐ Epilepsy	☐ Kidney Disorder	☐ Frequent Headaches
☐ Diabetes	☐ Radiation Therapy	☐ Depression
☐ Liver Disorder/Hepatitis	☐ Excessive Thirst	☐ Cancer/Tumor
☐ Lung/Breathing Problems		

12. Is there a tendency in your family towards illness? ☐ Yes ☐ No
    ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Other: _____
13. Women: Are you pregnant? ☐ Yes ☐ No If so, which month? _____
    Have you reached menopause? ☐ Yes ☐ No
14. Please describe any previous or current medical treatment, impending surgery, or any other medical information not listed above: _____
    _____
    _____

DENTAL HISTORY

1. Do you presently have any dental pain or discomfort? ☐ Yes ☐ No
   If so, please explain: _____
2. Date of last dental visit: _____What was done? _____
3. Date of Last dental cleaning: _____Frequency of cleanings: _____
4. How often did you visit the dentist in the past? _____
5. Have you had previous periodontal treatment? ☐ Yes ☐ No
   If so, please explain:_____
6. Have you ever had your teeth straightened? ☐ Yes ☐ No
7. Do your gums bleed? ☐ Yes ☐ No
8. Have you noticed any loose or shifting teeth? ☐ Yes ☐ No
9. Are your teeth sensitive to ☐ heat, ☐ cold, or ☐ sweets?
10. Are you conscious of bad mouth odors or tastes? ☐ Yes ☐ No
11. How often do you brush your teeth? _____
12. Is your toothbrush ☐ hard, ☐ medium, ☐ soft, or ☐ electric?
13. Do you floss? ☐ Yes ☐ No, If so, how often? _____
14. Do you use toothpicks? ☐ Yes ☐ No
15. Do you use a water irrigation device? (Water Pik) ☐ Yes ☐ No
16. Do you have a habit of biting your lip, tongue, or cheek? ☐ Yes ☐ No
17. Do you clench or grind your teeth during the day or night? ☐ Yes ☐ No
18. Do you have ☐ clicking, ☐ popping, or ☐ pain in the jaw joints? ☐ Yes ☐ No
19. Did your mother, father, brother, or sister lose all their natural teeth? ☐ Yes ☐ No

_____

Signature of Patient, Parent, or Guardian Date

Please update us with any changes to your health.

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