LOUIS C. FRANZETTI, D.D.S.
Periodontics — Implant Dentistry

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HEALTH QUESTIONNAIRE

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Birth Date_____ Today's Date _____

Name _____

Home Address_____

Home Phone _____

_____
City State Zip Code

Business Address _____

_____
Company Name Number and Street

Business Phone_____

_____
City State Zip Code

Age _____ Sex____ Height _____ Weight_____ Occupation _____

Married____ Single _____ Spouse's Name _____ Occupation _____

Closest Relative _____

Phone Number _____

Primary Physician _____ Address_____

Phone _____

Primary Dentist _____ Address_____

Phone _____

Last Physical Examination _____

Referred By_____

Last Dental Treatment _____ Procedure _____

Give your reason(s) for seeking periodontal treatment

_____

_____

Dental Insurance Information:

Social Security Number _____

Insurance Carrier Name _____

Insurance Group Number _____

Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 to 10 where 1 is severe disease (anticipated loss of some teeth) and 10 is optimal health. _____

On the following questions, circle the correct answer, mark any question you are unsure of UNKNOWN.

				Comment
1. Are you experiencing pain from your mouth at this time?	NO	YES	UNKNOWN	Where?
2. Have you ever had periodontal (gum) treatment? When? _____ When?_____ Doctor _____	NO	YES	UNKNOWN	
3. Did either your mother or father lose all their natural teeth?	NO	YES	UNKNOWN	
4. Have you had swollen areas on your gums, gum boils, or abscesses?	NO	YES	UNKNOWN	Which?
5. Do your gums bleed?	NO	YES	UNKNOWN	
6. Have you noticed bad odors or tastes?	NO	YES	UNKNOWN	Which?
7. Do you frequently breathe through your mouth?	NO	YES	UNKNOWN	
8. Do you chew gum, hard candies, or antacid tablets?	NO	YES	UNKNOWN	Which?
9. Do you frequently have fever blisters, mouth ulcers, or sores in your mouth or on your lips?	NO	YES	UNKNOWN	
10. Have you ever had trench mouth?	NO	YES	UNKNOWN	When?
11. Do you have any teeth that are sensitive to heat, cold, or sweets?	NO	YES	UNKNOWN	Which?
12. Do you have any loose teeth?	NO	YES	UNKNOWN	

13. Have your teeth separated lately, creating spaces between them?	NO	YES	UNKNOWN	
14. Have you ever worn braces to straighten your teeth?	NO	YES	UNKNOWN	
15. Are you dissatisfied with the appearance of your teeth?	NO	YES	UNKNOWN	
16. Do foods wedge between your teeth?	NO	YES	UNKNOWN	
17. Have you been under more nervous tension than average lately?	NO	YES	UNKNOWN	Why?
18. Do you smoke?	NO	YES	UNKNOWN	What? How much?
19. Are you aware of clenching, gritting, or grinding your teeth?	NO	YES	UNKNOWN	While awake? While asleep?
20. Are you aware of the way your teeth fit together?	NO	YES	UNKNOWN	
21. Do you chew on one side of your mouth?	NO	YES	UNKNOWN	Which?
22. Do you have headaches regularly?	NO	YES	UNKNOWN	Side of head? Migraine type?
23. Do you have any teeth which are tender to biting or pressure?	NO	YES	UNKNOWN	
24. Do you frequently bite your lip, cheek, fingernails, or objects (such as pipes, pencils, bobby pins)?	NO	YES	UNKNOWN	Which?
25. Do you frequently press your tongue against your teeth?	NO	YES	UNKNOWN	
26. Do you have any idea what periodontal treatments are and what they do for you?	NO	YES	UNKNOWN	Which?
27. Would you be tremendously disturbed if you had to lose your teeth and wear false teeth?	NO	YES	UNKNOWN	
28. Are you in good health?	NO	YES	UNKNOWN	When?
29. Are you willing to spend a total of 20 minutes daily for periodontal disease control?	NO	YES	UNKNOWN	Which?
30. Do you brush your teeth at least twice daily?	NO	YES	UNKNOWN	
31. Do you ever use dental floss, toothpicks, water sprays, or gum stimulators?	NO	YES	UNKNOWN	How often?
32. Have you ever had a frightening experience with dentistry?	NO	YES	UNKNOWN	
33. Do you know that patients undergoing periodontal treatment experience minimal discomfort?	NO	YES	UNKNOWN	
34. Do you form calculus (tartar) or plaque rapidly on	NO	YES	UNKNOWN	

your teeth or been told you do?				
35. Has there been any change in your general health within the past year?	NO	YES	UNKNOWN	Which area?

36. Are you under the care of a physician?	NO	YES	UNKNOWN	What for?
37. Have you ever had a major illness or operation?	NO	YES	UNKNOWN	What for?
38. Have you ever had any problems with surgery or anesthesia?	NO	YES	UNKNOWN	What?
39. Have you ever been hospitalized?	NO	YES	UNKNOWN	

40. Do you have or have you had any of the following diseases or conditions?

- rheumatic fever or rheumatic heart disease	NO	YES	*- pacemaker*	NO	YES
- congenital heart problem (murmur, prolapsed valve)	NO	YES	*- AIDS/HIV positive*	NO	YES
- heart attack	NO	YES	*- arthritis*	NO	YES
- rheumatism (painful, swollen joints)	NO	YES	*- stroke*	NO	YES
- hepatitis, jaundice or liver disease	NO	YES	*- stomach ulcers*	NO	YES
- high blood pressure	NO	YES	*- kidney trouble*	NO	YES
- low blood pressure	NO	YES	*- tuberculosis*	NO	YES
- persistent cough or cough up blood	NO	YES	*- arteriosclerosis*	NO	YES
- chest pain or exertion	NO	YES	*- venereal disease*	NO	YES
- psychiatric treatment/counseling	NO	YES	*- bypass surgery*	NO	YES
- shortness of breath	NO	YES	*- anemia*	NO	YES
- swollen ankles	NO	YES	*- glaucoma*	NO	YES
- hives or skin rash	NO	YES	*- thyroid trouble*	NO	YES
- fainting spells or seizures (epilepsy)	NO	YES	*- porphyria*	NO	YES
- illness that lasted more than one week	NO	YES	*- Diabetes*	NO	YES
- Other	NO	YES	*- allergy*	NO	YES

Please list any allergies, including allergies to medications:

41. Are you **presently taking** or **have you taken** any of the following drugs or medications with in the past year?

- antibiotics or sulfa drugs	NO	YES	*- tranquilizers*	NO	YES
- anticoagulants (blood thinners)	NO	YES	*- sleeping pills*	NO	YES
- medicine for high blood pressure	NO	YES	*- vitamins*	NO	YES
- cortisone (steroids)	NO	YES	*- aspirin*	NO	YES
- marijuana or other recreational drugs	NO	YES	*- hormones*	NO	YES
- medication you purchase yourself without a prescription	NO	YES	*- nitroglycerine*	NO	YES
- insulin, tolbutamide or similar drugs	NO	YES	*- digitalis or similar drugs*	NO	YES
- other	NO	YES	*- bisphosphonates*	NO	YES

42. Do you have to urinate (pass water) more than 6 times a day?	NO	YES	UNKNOWN	
43. Are you thirsty much of the time?	NO	YES	UNKNOWN	
44. Does your mouth frequently become dry?	NO	YES	UNKNOWN	Day?____ Night?_____
45. Do you feel numbness or tingling in any part of	NO	YES	UNKNOWN	Where?

your body?				
46. Have you had abnormal bleeding with extractions, surgery, or trauma?	NO	YES	UNKNOWN	
47. Do you bruise easily?	NO	YES	UNKNOWN	
48. Have you ever required a blood transfusion?	NO	YES	UNKNOWN	
49. Are you short of breath after climbing one flight of stairs?	NO	YES	UNKNOWN	
50. Are you short of breath after climbing two flights of stairs?	NO	YES	UNKNOWN	
51. Do you have any blood disorders?	NO	YES	UNKNOWN	
52. Have you had surgery or x-ray treatment for a tumor growth or malignancy?	NO	YES	UNKNOWN	
53. Are you employed in a situation which exposes you regularly to x-rays or ionizing radiation?	NO	YES	UNKNOWN	
54. Do you sleep well?	NO	YES	UNKNOWN	
55. Are your parents living?	NO	YES	UNKNOWN	
56. Has anyone in your family ever had: diabetes, tuberculosis, porphyria, heart disease, stroke, or any other disease or condition?	NO	YES	UNKNOWN	What? Who?
57. Do you wear contact lenses?	NO	YES	UNKNOWN	
58. Does your back ever give you trouble?	NO	YES	UNKNOWN	
59. What do you usually take for a headache or other pain?				
WOMEN ONLY (men go to question 69)	NO	YES	UNKNOWN	
60. Are you pregnant?	NO	YES	UNKNOWN	
61. Are you anticipating becoming pregnant?	NO	YES	UNKNOWN	
62. Are you nursing?	NO	YES	UNKNOWN	
63. Have you ever had a miscarriage?	NO	YES	UNKNOWN	
64. Do you have any problems associated with your menstrual period?	NO	YES	UNKNOWN	
65. Are you in or have you passed through menopause (change of life)?	NO	YES	UNKNOWN	
66. Have you had a hysterectomy or other female surgery?	NO	YES	UNKNOWN	
67. Do you take birth control pills or hormones?	NO	YES	UNKNOWN	
68. Do you have any disease, condition or problem	NO	YES	UNKNOWN	

not listed above that you think I should know about? If yes, please explain.					
DIET					
69. Please check if you eat the following daily?					
- meat	NO	YES	*- fruits*	NO	YES
- vegetables	NO	YES	*- grain/cereal*	NO	YES
- milk/other dairy products	NO	YES	*- eggs*	NO	YES
70. Do you eat breakfast, lunch, and dinner?	NO	YES	If no, which?		
71. Are you on or have you ever been on a special diet?	NO	YES	If yes, What for?		
72. Do you drink some form of alcohol daily?	NO	YES	If yes, how much?		
73. Are you aware that recent research has suggested that infected gums may increase the dangers associated with diabetes, heart diseases, stroke, lung damage and/or (if female) delivering a premature/low-birth-weight baby?	NO	YES			

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor.

Signature _____ Date _____

Comments:

_____
_____
_____
_____

Print Form