

**MARK E. GLOVER, D.D.S., M.S.D., P.C.**  
**PERIODONTICS AND IMPLANTS**  
 DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

**PERSONAL HISTORY** (Please Print)

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_ Birthdate \_\_\_\_\_ Height \_\_\_' \_\_\_" Weight \_\_\_\_\_ lbs. Who referred you to our office? \_\_\_\_\_  
 Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Change of Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_ x \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
 Change of business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Name of Spouse \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_ x \_\_\_\_\_  
 Closest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_  
 Do you have Dental Insurance? \_\_\_ Company Name \_\_\_\_\_ Phone \_\_\_\_\_ x \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Contact \_\_\_\_\_  
 Party responsible for payment of account not covered by insurance \_\_\_\_\_  
 Your Physician \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of last physical \_\_\_\_\_ Reason for Exam \_\_\_\_\_ Findings \_\_\_\_\_  
 Your Pharmacy \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_  
 Your Dentist \_\_\_\_\_ How Long \_\_\_\_\_ Date of last exam \_\_\_\_\_ Findings \_\_\_\_\_

**DENTAL HISTORY**

1. What problems prompted you to make this appointment with Dr. Glover \_\_\_\_\_
2. Please check any of the symptoms below which may be related to your present condition:
 

<input type="checkbox"/> Pain	<input type="checkbox"/> Receding gums	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Sore muscles
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Sore teeth	<input type="checkbox"/> Changing bite	<input type="checkbox"/> Spaces between teeth
<input type="checkbox"/> Sore gums	<input type="checkbox"/> Sensitive teeth	<input type="checkbox"/> Jaw popping	<input type="checkbox"/> Bad breath / bad taste
<input type="checkbox"/> Swollen gums	<input type="checkbox"/> None of the Above	<input type="checkbox"/> Other: _____	
3. Please check any of the following that you have now or have ever had:
 

<input type="checkbox"/> Braces	<input type="checkbox"/> Gum abscesses	<input type="checkbox"/> Implants	<input type="checkbox"/> Broken jaw
<input type="checkbox"/> Crowns	<input type="checkbox"/> Tooth extractions	<input type="checkbox"/> Dentures	<input type="checkbox"/> Trench mouth
<input type="checkbox"/> Bridges	<input type="checkbox"/> Root canals	<input type="checkbox"/> Fever blisters	<input type="checkbox"/> Dry Mouth
4. Please check any of the following periodontal treatments you have had:
 

<input type="checkbox"/> Root planing / curettage	<input type="checkbox"/> Bite adjustments	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Gum surgery
<input type="checkbox"/> Periodontal cleanings	<input type="checkbox"/> Biteguards /splints	<input type="checkbox"/> Gum grafts	<input type="checkbox"/> Bone grafts
<input type="checkbox"/> None of the above	<input type="checkbox"/> Other: _____		
5. Please check any of the following aids you use to clean your teeth:
 

<input type="checkbox"/> Toothbrush	<input type="checkbox"/> Toothpaste	<input type="checkbox"/> Water Pik	<input type="checkbox"/> Toothpick
<input type="checkbox"/> Floss	<input type="checkbox"/> Mouth rinse	<input type="checkbox"/> Electric brush	<input type="checkbox"/> Stimudent
6. How often do you see your dentist for cleanings or checkups? \_\_\_\_\_
7. Can you chew satisfactorily?.....  Yes  No
8. Would the loss of your teeth disturb you?.....  Yes  No
9. Are you pleased with the appearance of your teeth?.....  Yes  No
10. Does your bite feel even?.....  Yes  No
11. Do you clench or grind your teeth when stressed or at night?...  Yes  No
12. Have you had a frightening experience in a dental office?.....  Yes  No
13. Do you have any blood relations who lost all of their teeth?.....  Yes  No
14. Do you chew gum, mints, lifesavers or antacids regularly ?.....  Yes  No
15. Do you eat many candies, cookies, desserts or other sweets?....  Yes  No
16. Estimate the number of cups or glasses, etc. you consume each day of : Coffee\_\_\_ Tea\_\_\_ Soft drinks \_\_\_\_\_  
 Alcoholic beverages \_\_\_\_\_

## MEDICAL HISTORY

1. Please check any of the following that you now have or have ever had:
 

<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heart murmur or defect	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Systemic lupus erythematosus	<input type="checkbox"/> Seizure Disorders	<input type="checkbox"/> Bladder problems
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Artificial joint	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> AIDS / ARC
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Chest pain or angina	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart disease or attack	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> None of the Above
  
2. Please put one check by any medications that you have a known allergy or reaction to:
 

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Vicodin	<input type="checkbox"/> Valium	<input type="checkbox"/> Demerol
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Darvocet	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Versed	<input type="checkbox"/> Morphine
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Benzocaine	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ativan	<input type="checkbox"/> Nubain
<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Xylocaine	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Halcion	<input type="checkbox"/> Fentanyl
<input type="checkbox"/> None of the Above	<input type="checkbox"/> Others (please list): _____			
  
3. Are you currently taking any medications (pills, drugs, aspirin, vitamins, etc.)? If so please list \_\_\_\_\_  
 \_\_\_\_\_
  
4. Please check any medications you have taken in the last 12 months other than the ones previously listed:
 

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Aspirin	<input type="checkbox"/> High blood pressure medication
<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Stomach ulcer medication
<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Thyroid tablets	<input type="checkbox"/> Digitalis or drugs for heart
<input type="checkbox"/> Blood thinners	<input type="checkbox"/> Hormonal therapy	<input type="checkbox"/> Recreational drugs
<input type="checkbox"/> Pain relievers	<input type="checkbox"/> Cortisone	<input type="checkbox"/> Diabetic medication
<input type="checkbox"/> Nitroglycerin	<input type="checkbox"/> Steroids	<input type="checkbox"/> None of the Above
<input type="checkbox"/> Others _____		
  
5. How would you classify your susceptibility to medications?     Sensitive     Average     Resistant
6. Do you smoke or use tobacco in any way?     Yes     No    If yes, how many packs per day? \_\_\_\_ How many years? \_\_\_\_
7. Have you been sedated or hospitalized for any reason?     Yes     No    If yes, please list the procedure, year and any complications \_\_\_\_\_  
 \_\_\_\_\_
  
8. Do you have shortness of breath after climbing stairs?.....     Yes     No
9. Do you get up more than one time at night to urinate?.....     Yes     No
10. Do you have excessive thirst or hunger?.....     Yes     No
11. Do you wear contact lenses?.....     Yes     No
12. Have you had abnormal bleeding with previous minor cuts, tooth extractions, or surgery?     Yes     No
13. Do you bruise easily? .....     Yes     No
14. Have you ever had radiation treatment for a cancer, tumor, growth, or other condition?..     Yes     No
15. Have you been in drug or alcohol rehabilitation?.....     Yes     No
16. Are you in a high risk group for contracting AIDS?.....     Yes     No
17. Do you have any other conditions that you feel we ought to be aware of?.....     Yes     No  
 If yes, please explain \_\_\_\_\_
18. WOMEN ONLY:    Have you had a baby weighing over 9 pounds at birth? .....     Yes     No  
 Are you pregnant?.....     Yes     No    Taking birth control pills?.....     Yes     No  
 Had a hysterectomy? ... Yes     No    Been through menopause?.....     Yes     No
19. I agree to assign any insurance benefits towards treatment rendered.

Patient's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Periodontist's Signature \_\_\_\_\_ Date \_\_\_\_\_