Southern Oregon
Periodontics
Promoting Health and Harmony
Chun-Han Chou, DDS, MS

Medical Questionnaire

Medications

Please List any medications you are currently taking including pre-med for dental appointments & daily aspirin.

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Allergies (check all that apply)

Other:____

- ☐ Penicillin
- ☐ Latex
- ☐ Codeine
- ☐ Aspirin
- ☐ Sulfa
- ☐ Benadryl
- ☐ Tetracycline
- ☐ Iodine
- ☐ Cortisone
- ☐ Metronidazole
- ☐ Clindamycin
- ☐ Azithromycin
- ☐ Dental Anesthetic

Have you had in the past or present?

- ☐ Abnormal Bleeding
- ☐ Addiction issues (alcohol /drugs / meds)
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Condition
- ☐ Blood Thinner
  Recent INR ________
  (Coumadin/ Warfarin)
- ☐ Breathing issues
- ☐ Cancer
- ☐ Chemo / Radiation
- ☐ Colitis
- ☐ Complications from surgery
- ☐ Cortisone (recently)
- ☐ Depression/ Bipolar
- ☐ Diabetes Recent A1C________
- ☐ Dry Mouth
- ☐ Endocarditis
- ☐ Fainting Spells
- ☐ Migraines /Frequent headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Condition (please list details below)
- ☐ Heart Valve replacement
- ☐ Hepatitis: A / B / C
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ HIV or AIDS
- ☐ Joint replacement
  When_________
  Type___________
  Premed needed? Y N
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mouth or Lip Sores/ Ulcers
- ☐ Osteoporosis (medicated y/n)
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Seizures / Epilepsy
- ☐ Sexually Transmitted Disease
- ☐ Shingles (recently)
- ☐ Sinus (Chronic issues)
- ☐ Smoker (Any kind)
- ☐ Previous Smoker
- ☐ Chewing tobacco user
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers

Current Issues

- ☐ Anemia
- ☐ Birth Control
  Type: Pill / Injection / Implant
- ☐ Pregnant
  How many wks_________
- ☐ Nursing

Please provide any additional information related to your conditions and/or describe any conditions not yet listed above:

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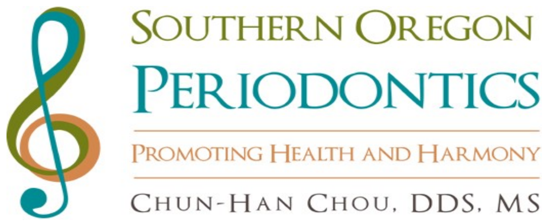
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Southern Oregon Periodontics and its staff, responsible for any action they take or do not take because of error or omissions that I have made in the completion of this form.

Signature____ Date ________________



Patient Registration

Date_________________

Patient____(______________________________)
Last Name First Name Middle Initial Preferred Name

Sex M F Age_________ Birth date: __________________ ☐ Married ☐ Single ☐ Other

Pronouns They/Them She/Her He/Him Other____________________________

Mailing Address ____City ______________________________________
State___________Zip______________________ E-Mail____

Cell Phone (__________)____________________________________Home Phone (__________)____________________________________
Work phone (__________)___________________________________ **Which method of contact is preferred** (Circle any) Call Text Email

Do we have permission to:
Send text confirmations/reminders? **Y/N**
Leave Messages regarding your dental care and financial information? **Y/N**
Discuss your dental care with household members? **Y/N**
Discuss co-pay & financial information with household members? **Y/N**

Preferred Days and Times for Appointments
(Circle any that apply)
Mon / Tues / Wed / Thurs / Fri
Morning / Afternoon

Emergency Contact: Name____ Relationship____
Phone Number(__________)___________________________________

Medical Primary Physician's Name____City ______________________________
Preferred pharmacy____ Location/City: ____

DENTAL HISTORY

General Dentist Name____
Reason for referral:____
Have you had any complications with previous dental treatment? Yes No
When was your last Dental Cleaning________________ How often do you get your teeth cleaned__________________
Have you ever been under the care of a periodontist? Where? ____
Are you experiencing any dental pain/where?_________________Describe: __________________________________

GINGIVAL HEALTH & ORAL HYGIENE

I use a: Manual tooth brush or Electric tooth brush
I brush for ______minutes______ times a day. I floss___________times a week. I rinse with______________________
Any other oral hygiene aids?____

IMPROVING ESTHETICS & FUNCTION

I would like to replace missing teeth Yes No I would like to learn about dental implants Yes No