

BARRY J. GELBER, D.D.S.
 1185 Silas Dean Hwy.
 Wethersfield, CT 06109
 GelberPerio.com

Tel: 860-563-2331
 Fax: 860-257-7278

HEALTH HISTORY

NAME _____ DOB ___/___/___ MARITAL STATUS _____
 ADDRESS _____ CITY _____ ZIP _____ TEL _____
 OCCUPATION _____ EMPLOYER _____ SS# ___-___-___
 BUSINESS ADDRESS _____ BUSINESS TEL # _____
 REFERRED BY _____ SPOUSE NAME _____
 NAME OF DENTIST _____ CITY _____
 HOW LONG HAVE YOU BEEN WITH YOUR PRESENT DENTIST? _____
 NAME OF
 PHYSICIAN _____ CITY _____
 DATE OF LAST PHYSICAL
 EXAM ___/___/___ FINDINGS _____

WHAT IS YOUR ESTIMATION OF YOUR GENERAL HEALTH? GOOD ___ FAIR ___ POOR ___

Circle One

1. Are you now under the care of a physician?
 YES NO Don't know
 Specialist Name: _____

2. List any medications you are taking or have taken
 this past year _____

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

Joint Replacement (hip, knee)	Yes No Don't know	Sinusitis	Yes No Don't know
Rheumatic Fever	Yes No Don't know	Radiation Therapy	Yes No Don't know
Scarlet Fever	Yes No Don't know	Tendency to Faint	Yes No Don't know
Heart Murmur	Yes No Don't know	Diabetes	Yes No Don't know
Heart Problems	Yes No Don't know	Seizure/Convulsions	Yes No Don't know
Heart Surgery	Yes No Don't know	Emphysema	Yes No Don't know
Heart Attack	Yes No Don't know	Thyroid Disorder	Yes No Don't know
High Blood Pressure	Yes No Don't know	Hepatitis, Liver Disease	Yes No Don't know
Stroke	Yes No Don't know	Kidney Problems	Yes No Don't
Abnormal Blood Count	Yes No Don't know	Arthritis, Rheumatism	Yes No Don't know
Tumor or Growth	Yes No Don't know	Ulcers	Yes No Don't know
Asthma	Yes No Don't know	Tuberculosis	Yes No Don't know
Frequent Headaches	Yes No Don't know	Venereal Disease	Yes No Don't know
Osteoporosis	Yes No Don't know	Osteopenia	Yes No Don't know

4. Have you ever knowingly been exposed to the AIDS virus? Yes No Don't know
 5. Has your general health changed in the past year? Yes No Don't know
 6. Have you ever had any serious illnesses or major operations? Yes No Don't know
 7. Have you had abnormal bleeding associated w/previous tooth extraction, surgery or trauma? Yes No Don't know
 8. Do you heal slowly? Yes No Don't know
 9. Bisphosphonates: Fosamax, Boniva, Actonel, Reclast? Yes No Don't know
 10. Have you ever had any allergies (food, dust, drugs, etc.)? Yes No Don't know

CONTINUED ON THE BACK

11. Are you allergic or have you had an adverse reaction to any of the following:
- | | | | |
|--------------------------------------|-----|----|------------|
| Dental Anesthetics (novacaine, etc.) | Yes | No | Don't know |
| Penicillin | Yes | No | Don't know |
| Tetracycline | Yes | No | Don't know |
| Codeine | Yes | No | Don't know |
| Latex | Yes | No | Don't know |
| Other: | | | |
12. Have you been warned against taking any drug or medicine? Yes No Don't know
13. Are you frequently short of breath or have chest pain after mild exertion? Yes No Don't know
14. Do you have to get up often at night to urinate? Yes No Don't know
15. Have you ever been tested for diabetes? Yes No Don't know
17. Do you have a persistent cough or do you cough up blood? Yes No Don't know
18. Do you consider yourself a nervous person? Yes No Don't know
19. Have you ever received psychiatric care or psychotherapy? Yes No Don't know
20. Do you smoke? If so, how much? _____ Yes No Don't know

FOR WOMEN ONLY

21. Are you pregnant? _____ Month of Pregnancy _____
22. Date of last menstrual period _____ Or onset of menopause _____
23. Are you taking female hormones? (birth control, estrogens) Yes No Don't know

DENTAL HISTORY

24. Reason for visit: _____

25. Do you presently have dental pain? If so, please describe Yes No Don't know

26. Are you aware of:	Yes	No		Yes	No
Bleeding gums	___	___	Painful Gums	___	___
Bad taste or breath	___	___	Shifting or loose teeth	___	___
Receding gums	___	___	Clenching, grinding of teeth	___	___
Sensitive teeth	___	___	Gagging	___	___
27. Do you have difficulty chewing your food?				Yes	No Don't know
28. Have you ever been told you have "trench mounth" or periodontal disease (pyorrhea)?				Yes	No Don't know
29. Have you ever had orthodontic treatment (braces)?				Yes	No Don't know
30. Have you had previous periodontal treatment?				Yes	No Don't know
31. Have you ever had instruction on how to care for your teeth?				Yes	No Don't know
32. Have you ever had any complications associated with any previous dental treatment?				Yes	No Don't know

PLEASE NOTIFY THE DOCTOR OF ANY CHANGES IN YOUR HEALTH

SIGNED _____ **DATE** ___ / ___ / ___

OFFICE USE
BP _____
Pulse _____