Gavin M. Aaron, DDS, MS

Periodontics and Oral Diagnosis

3005 Peters Creek Road
Roanoke, VA 24019

LAST NAME | FIRST NAME | MIDDLE | BIRTH DATE MO.-DAY-YR. | HEIGHT | WEIGHT | MARITAL STATUS

NAME YOU WOULD LIKE TO BE CALLED | PATIENT SOCIAL SECURITY #

RESIDENCE ADDRESS | CITY | STATE | ZIP | RESIDENCE TELEPHONE

CELL PHONE# | NAME OF SPOUSE/PARENT | EMERGENCY TELEPHONE

EMPLOYER | ADDRESS | CITY | STATE | ZIP | BUSINESS TELEPHONE

REFERRED BY | NAME OF PHYSICIAN | TELEPHONE

GENERAL	Circle One	
1) Has there been any change in your general health during the last year?	Yes	No
2) Are you receiving any treatment by any doctor now?	Yes	No
3) Are you taking any medicines now? If yes, list at bottom of page.	Yes	No
4) Have you ever had an operation?	Yes	No
5) Have you ever had a serious illness?	Yes	No
6) Have you ever been hospitalized?	Yes	No
7) Has a dentist or physician ever told you that you had a tumor or a cancer?	Yes	No
8) Have you ever had radiation or chemo therapy treatments?	Yes	No
9) Have you had rheumatic fever, growing pains, or twitching of the limbs?	Yes	No
10) Have you had a stroke (apoplexy, CVA)?	Yes	No
11) Have you ever had excessive bleeding following extraction of teeth or from a cut?	Yes	No
12) Are you allergic or sensitive to any particular medicine (Penicillin - Codeine)? If yes, list at bottom of page.	Yes	No
13) Have you ever been told not to take novocaine?	Yes	No
14) Do you suffer from frequent or severe headaches?	Yes	No
15) Do you have spells of dizziness?	Yes	No
16) Have you ever had severe pains of the face or head?	Yes	No
17) Do you have hay fever?	Yes	No
18) Do you have sinus trouble?	Yes	No
19) Have you ever been diagnosed HIV positive?	Yes	No
20) Are you or have you ever been addicted to any medications, substances or alcohol?	Yes	No
21) Do you use tobacco? If yes, how often?____	Yes	No
CARDIOVASCULAR		
22) Has a physician ever said you had heart trouble?	Yes	No
23) Have you ever had rheumatic heart disease?	Yes	No
24) Have you ever had a heart attack?	Yes	No
25) Has a physician ever said your blood pressure was too high or too low?	Yes	No
26) Do you get out of breath easily?	Yes	No
27) Do you bruise easily?	Yes	No
28) Do you have a heart murmur?	Yes	No
29) Do you pre-medicate for dental visits?	Yes	No
GASTRO-INTESTINAL		
30) Do you suffer from stomach trouble?	Yes	No
31) Have you ever had liver trouble?	Yes	No
32) Do you have frequent diarrhea?	Yes	No
33) Has a physician ever told you that you had ulcers?	Yes	No
34) Are there any foods you cannot eat?	Yes	No
35) Have you ever had hepatitis?	Yes	No
RESPIRATORY		
36) Do you have asthma?	Yes	No
37) Have you ever had tuberculosis?	Yes	No
GENITO-URINARY		
38) Do you have kidney or bladder trouble?	Yes	No
39) Have you ever had syphilis?	Yes	No
FEMALE		
40) Are you currently pregnant?	Yes	No
41) Have you reached menopause?	Yes	No
ENDOCRINE SYSTEM		
42) Do you have diabetes?	Yes	No
43) Has any family member had diabetes?	Yes	No
44) Have you ever taken thyroid tablets?	Yes	No
NERVOUS SYSTEM		
45) Have you ever had a nervous breakdown?	Yes	No
46) Do you have epilepsy?	Yes	No
47) Are you a nervous person?	Yes	No
BONES AND JOINTS		
48) Do you have arthritis or rheumatism?	Yes	No
49) Do you have any artificial prosthetic joints?	Yes	No
DENTAL		
50) Do your gums bleed when you brush your teeth?	Yes	No
51) Have you ever seen a periodontist?	Yes	No
52) Do your teeth ever feel sore when you bite on them?	Yes	No
53) Do you think your teeth are moving or drifting?	Yes	No
54) Do you grind or clinch your teeth when you are nervous or while sleeping?	Yes	No
55) Do you feel that an attempt to save your teeth is a waste of time?	Yes	No

Patient's Signature _____ Date _____

Chief Complaint: _____

Medications taking: _____

_____

Allergic to: _____

Name