PROACTIVEPERIO
Periodontics & Implant Dentistry

INITIAL PERIODONTAL CONSULTATION

Name: _____ D.O.B: _____

I was referred by: _____ First visit date: _____

The reason I am visiting is because of:

Periodontal/Gum Disease ❑ Implant/s ❑ which area? _____

Other ❑ _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

1.	Do your gums bleed when you brush?	Not at all ❑	A little ❑	A lot and sometimes spontaneously ❑
2.	Are your gums feeling tender or swollen?	Not at all ❑	A little ❑	A lot ❑
3.	Does food get stuck in between your teeth?	Not at all ❑	A little ❑	A lot ❑
4.	Do you have mobile or loosened teeth?	Not at all ❑	1 or 2 teeth If so, where?	3 or more teeth If so, where?
5.	Do you have sensitive teeth?	Not at all ❑		Yes ❑. If so, to what? Cold / Hot / Sweets [please circle]
6.	Do you suffer from mouth malodour (bad breath)?	Not at all ❑		Yes ❑ If so, when did this begin?
7.	Do you experience a bad taste in your mouth?	Not at all ❑		Yes ❑ If so, when did this begin?
8.	Do you have difficulties chewing?	Not at all ❑		Yes ❑ I am avoiding specific foods or favouring one side of my mouth
9	Do you clench or grind your teeth	Not at all ❑		Yes ❑ If so, is it during the day or at night?

DENTAL TREATMENT HISTORY

1.	I have regular dental check-ups (at least 1x a year)	NO ❑	YES ❑	Only if in pain ❑
2.	Have you ever visited a periodontist before?	NO ❑	YES ❑	Yes ❑ If so, what treatments have you had and how long ago was this?

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info@proactiveperio.com
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3.	Have you ever had orthodontic treatment	NO ❑	YES ❑	Yes ❑ How long ago? Invisalign or Braces?
4.	Have you ever had dental implants in the past	NO ❑	YES ❑	Yes ❑ Where? Who completed them?
5.	Have you ever had dental implants in the past	NO ❑	YES ❑	Yes ❑ How many? How long ago?
6.	Have you had any teeth removed	NO ❑	YES ❑	Yes, Pain ❑ Tooth broke ❑ Became loose ❑
7.	Do you wear a partial or full denture(s)?	NO ❑	YES ❑	Yes ❑ How long and when were they last checked/ relined?
8.	Approximately, my last dental check-up and clean was?			

DENTAL HYGIENE

1. I clean my teeth _____ times a day with:

Manual toothbrush ❑ Soft, Medium or Hard (please circle)		Electric toothbrush ❑
2 I use Mouthwash ❑	Dental floss ❑	Interdental brush ❑ (Tepe/Pixter etc)

LIFESTYLE

I am a:

Non-smoker ❑	Former smoker ❑	I quit _____ yrs. ago
Current smoker ❑	_____ Cigs/day for____ years	Thinking of quitting ❑

FAMILY MEDICAL HISTORY

Diabetes ❑ Periodontal Disease ❑ Cardiovascular ❑

OTHER INFORMTION

I hereby certify that all the information provided in this form are accurate and correct as at the date of completion of this form.

Signature: _____ Date: _____

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