RAVENEL PERIODONTICS, PA
Dr. Lisa Ravenel
1130 E Butler Rd
Greenville, SC 29607

Dental History

Patient Name: ____ Date: ___________________________

General Dentist: ____

Date of last dental examination: __________________ Date of last dental cleaning: ______________________

1: Do you have any current dental complaints? ____

Question		
2: Are you satisfied with the appearance of your teeth?	YES ☐	NO ☐
3: Would you be tremendously disturbed if you had to lose all your teeth?	YES ☐	NO ☐
4: Did either of your parents lose all of their natural teeth?	YES ☐	NO ☐
5: Have you ever seen a periodontist before?	YES ☐	NO ☐
6: Do your gum tissues bleed?	YES ☐	NO ☐
7: Do you form tartar or plaque rapidly or have been told that you do?	YES ☐	NO ☐
8: Have you noticed bad odors or tastes in your mouth?	YES ☐	NO ☐

9: What type of toothbrush do you use? Soft ☐ Medium ☐ Hard ☐

Manual ☐ Electric ☐

10: What else do you use to clean your teeth? ____

Question		
11: Do foods wedge between your teeth?	YES ☐	NO ☐
12: Are your teeth sensitive to thermal temperatures (hot, cold) or to sweets?	YES ☐	NO ☐
13: Do you have any abnormal lesions in your mouth?	YES ☐	NO ☐
14: Does your mouth frequently become dry?	YES ☐	NO ☐
15: Do you frequently breathe through your mouth?	YES ☐	NO ☐
16: Do you clench or grind your teeth during the day or night?	YES ☐	NO ☐
17: Do you chew on one side of your mouth?	YES ☐	NO ☐
18: Do you currently wear a bite splint (nightguard)?	YES ☐	NO ☐
19: Have you ever worn braces?	YES ☐	NO ☐
20: Have you ever had a frightening experience in dentistry?	YES ☐	NO ☐
21: Do you feel nervous when having dental treatment?	YES ☐	NO ☐
22: Does the fear of pain make you postpone dental treatment?	YES ☐	NO ☐
23: Would you like to use laughing gas or moderate IV sedation?	YES ☐	NO ☐
24: Is it important to you to keep your teeth?	YES ☐	NO ☐
25: Would spend 15 minutes a day keeping your natural teeth?	YES ☐	NO ☐
	YES ☐	NO ☐

Preferred Pharmacy: ____ Phone Number: _________________

MEDICAL HISTORY:

Medical Doctor: ___________________________________ Phone: _____________________________________

Date of last physical examination: ____

Have there been any changes in your general health during the last year? YES☐ NO☐

Are you or have you ever been on any bone density medication? (bisphosphonates?) YES☐ NO☐

Please list all current prescribed medications you are currently taking:

____

____

Please list all current over the counter medications you are currently taking:

____

____

Please list any food/medication allergies:

____

____

Please check any of the following health conditions that apply to you:

Diabetes☐	High Blood Pressure☐	Tobacco Use: Current☐ Former☐
Pre-Med☐	Heart Disease☐	Cigarettes☐ Chewing Tobacco☐
Allergy - Medications☐	Allergy - Foods☐	Epilepsy☐
Asthma☐	Anemia☐	Kidney Disease☐
Psychiatric Care☐	Thyroid Dysfunction☐	Pacemaker☐
Sinus Issues☐	Tuberculosis☐	Respiratory Issues☐
Arthritis☐	AIDS/HIV☐	Latex Allergy☐
Anxiety☐	Autoimmune Condition☐	Cancer☐
Radiation Treatment☐	Excessive Bleeding☐	Hepatitis☐ Type: _________
Blood Disease☐	Liver Disease☐	Pregnant☐ or Trying to get Pregnant☐
Stroke☐	Ulcers☐	Other: _____________________________________

Do you have any health problems that need further clarification? If so, please explain:

____

____

Signature of Patient or Guardian Date

____

Witness Signature Date