

Periodontics and Implant dentistry  
Sylvain Mouraret, DDS - Sylvain Leymarie, DDS

Last name..... First name.....  
 Date of birth ..... Gender F  M   
 Legal representative ..... Email.....  
 Phone number (Home.): ..... (Off.).....(Mob.).....  
 Adresse.....  
 Zip code..... City .....  
 Occupation..... You have known the dental office by.....

Aim of consultation:.....

**CHIEF COMPLAINT**

	Yes	No		Yes	No
. Dental pains	<input type="checkbox"/>	<input type="checkbox"/>	. Dental mobility	<input type="checkbox"/>	<input type="checkbox"/>
. Teeth sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>	. Gums bleeding	<input type="checkbox"/>	<input type="checkbox"/>
. Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	. Grinding of teeth	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL HISTORY**

. Cardiac disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
. Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Hormonal disorders	<input type="checkbox"/>	<input type="checkbox"/>
. Digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
. Liver disorders (if hepatitis specify A, B, C)	<input type="checkbox"/>	<input type="checkbox"/>	. Are you HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
. Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Problèmes ORL	<input type="checkbox"/>	<input type="checkbox"/>
. Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
. Eye disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Radiotherapy head or neck	<input type="checkbox"/>	<input type="checkbox"/>
. Broncho-pulmonary disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
. Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>	. Have you ever taken bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>
. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
. Other diseases?.....					
. Do you take medication?	<input type="checkbox"/>	<input type="checkbox"/>	Which ones?.....		
.....					
. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How many cigarettes ?.....		
. Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How much ?.....		

**WOMAN ONLY :**

. Are you pregnant ?	<input type="checkbox"/>	<input type="checkbox"/>	. Are you breast-feeding?	<input type="checkbox"/>	<input type="checkbox"/>
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**Date and Sign:**