

HEALTH/MEDICAL HISTORY

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. This questionnaire will become a part of your dental record and is considered "Confidential."

Are you currently under the care of a physician, physical therapist, and/or chiropractor? (circle) Yes No

If Yes, please explain _____

Date of last physical examination ____ / ____ / ____

Reason for last visit? _____

Physician' Name _____ Phone # _____

What medications are you currently taking (include over the counter, vitamins, and herbal supplements)?

Have you ever had an allergic reaction? To: (circle & identify) Medication _____

Food _____ Latex Products _____ Other _____

In the past, have you ever had to pre-medicate with an antibiotic prior to dental treatment? (circle) Yes No

In the past, have you ever had artificial joints or a heart valve replaced? (circle) Yes No When? _____

Have you ever been treated for or suffered from: (circle all that apply)

Blood Pressure: High or Low	Heart Disease	Heart Valve	Heart Murmur	Stroke
Bleeding/Clotting Disease	High Cholesterol	Diabetes	Depression	Rheumatic Fever
Hepatitis	HIV/Aids	Fibromyalgia	Tuberculosis	Seasonal Allergies
Sinus Problems	Bronchitis	Snoring	Asthma	Back Problems
Dizziness	Dry Mouth	Trouble breathing normally through your nose		

Other: _____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? (circle) Yes No

If Yes, please explain: _____

Has there been any change in your health in the past 2 years? (circle) Yes No

If Yes, please explain: _____

Do you now or have you ever used tobacco? (circle) Yes No

If you currently use tobacco, are you interested in quitting? (circle) Yes No

How many alcoholic drinks do you consume a week? _____

For women: Are you pregnant or do you think you may be pregnant? (circle) Yes No

DENTAL CONCERNS

Reason for today's visit: (circle) Examination/Cleaning Pain/Swelling Broken Tooth/Filling

If other than a cleaning, have you previously been treated for this problem or concern? (circle) Yes No

If Yes, please explain: _____

How long has this been a problem or concern? _____

TELL US ABOUT YOUR LAST DENTAL APPOINTMENT.....

When was your last dental exam & cleaning? _____

Was the treatment there comfortable? (circle) Yes No

If no, please explain: _____

Was the staff there friendly? (circle) Yes No

Were the fees explained before your appointments with your previous dentist? (circle) Yes No

Anything we have not thought of? _____

WHAT ARE YOUR FEELINGS ABOUT YOUR

FRONT TEETH

Are you happy with their color? (circle) Yes No

Are you happy with their length? (circle) Yes No

Are they crowded or crooked? (circle) Yes No *Are braces an option? (circle) Yes No

Are you happy with their overall appearance? (circle) Yes No

Anything about them you would change? _____

BACK TEETH

Are they sensitive to hot or cold foods? (circle) Yes No

Do they trap food when you eat? (circle) Yes No

Anything about them you would change? _____

GUMS

Do they ever bleed? (circle) Yes No *Are you seeing a periodontist? (circle) Yes No

Are they sensitive? (circle) Yes No If yes, Who? _____

Do you frequently have bad breath? (circle) Yes No

Anything about them you would change? _____

MISSING TEETH

Do you have any missing teeth? (circle) Yes No

Are you wearing a replacement? (circle) Yes No

Is your denture or partial comfortable? (circle) Yes No

If No, please explain: _____

Anything you would change? _____