

CONFIDENTIAL

PATIENT QUESTIONNAIRE

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

DENTAL HISTORY

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? Soft Medium Hard

	YES	NO		YES	NO
5. Do your gums bleed while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do your gums bleed while flossing?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel pain in any of your teeth when brushing or flossing them?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you clench or grind your teeth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are your teeth sensitive to hot, cold, sweet or sour foods/ liquids?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever experienced any of the following problems in your jaw?			17. Have you ever had:		
a. Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	a. Orthodontic treatment (braces)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>	b. Oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	c. Gum Treatment?	<input type="checkbox"/>	<input type="checkbox"/>
d. Difficulty chewing?	<input type="checkbox"/>	<input type="checkbox"/>	d. Your teeth ground or the bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
			e. Worn a bite plate or other appliance?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you noticed any loosening of teeth?	<input type="checkbox"/>	<input type="checkbox"/>	18. Are you satisfied with the appearance of you teeth?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever had an upsetting experience in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does food tend to become caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	20. Is there anything about having dental treatment that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO		YES	NO
1. Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have there been any changes in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
3. Date of last physical exam: _____			12. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
4. Physician's name _____ Address _____ Phone No. _____			Do you have any other medical condition you think we should know about?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	Women only:		
6. Have you ever been hospitalized for any surgical operation or serious illness? If yes, Please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	1. Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had any abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	2. Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	3. Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had a recent weight loss?	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL HISTORY CONTINUED

Are you allergic to or have you had reactions to:					
	YES	NO		YES	NO
1. Local anesthetics like lidocaine?	<input type="checkbox"/>	<input type="checkbox"/>	5. Iodine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>	6. Iodine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>	7. Other _____?	<input type="checkbox"/>	<input type="checkbox"/>
4. Barbiturates, sedatives or sleeping pills?					

Do you have or have you ever had the following:					
	YES	NO		YES	NO
1. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	14. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart trouble, heart attack or angina?	<input type="checkbox"/>	<input type="checkbox"/>	15. AIDS, HIV?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do your ankles swell	<input type="checkbox"/>	<input type="checkbox"/>	16. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	17. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
5. Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	18. Joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	19. Stomach ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
7. Liver disease, or jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	20. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
8. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	21. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
9. Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>	22. Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
10. Lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>	23. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
11. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	24. Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
12. Hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>	25. Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
13. Fainting spells or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the information listed is complete and accurate.

X _____ DATE _____
 (PATIENT, PARENT OR GUARDIAN) (EXAMINER)

FOR COMPLETION BY THE DENTIST:

SUMMARY OF MEDICAL HISTORY _____

SUMMARY OF DENTAL HISTORY _____

MEDICAL HISTORY UPDATE:		INITIALS:		
DATE	COMMENTS	PATIENT	DOCTOR	HYGIENIST
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____