PATIENT QUESTIONNAIRE **CONFIDENTIAL**

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

DENTAL HISTORY

1. Reason for visit: _____

2. When was your last dental visit? _____ Your last dental x-rays _____

3. How often do you brush your teeth? _____

	Yes	No
4. Do your gums bleed while brushing or flossing?	❑	❑
5. Do you feel any pain while brushing or flossing?	❑	❑
6. Are any teeth sensitive to hot, cold, or sweets?	❑	❑
7. Do you have any loose teeth?	❑	❑
8. Do you have any sores or lumps near your mouth?	❑	❑
9. Have you ever experienced any problems with your jaw?	❑	❑
10. Have you had any head, neck, or jaw injuries?	❑	❑
11. Do you clench or grind your teeth while awake or asleep?	❑	❑
12. Have you ever had:		
A. Orthodontics (Braces)	❑	❑
B. Oral Surgery	❑	❑
C. Gum Surgery	❑	❑
D. Worn a bite guard/splint	❑	❑
13. Are you satisfied with the appearance of your teeth?	❑	❑
14. Is there anything about dental Treatment that concerns you?	❑	❑

MEDICAL HISTORY

	Yes	No	If Yes, Please explain.
Are you under a physician's care now?	❑	❑	_____
Physicians name: _____	❑	❑	
Have you ever been hospitalized or had a major operation?	❑	❑	_____
Do you take aspirin daily?	❑	❑	_____
Do you use tobacco?	❑	❑	_____

Women: Are you: ❑ Pregnant/Possibly pregnant ❑ Nursing ❑ Taking oral contraceptives

Have you had an allergic reaction to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex

❑ Sulfa ❑ Dental Anesthetic ❑ Other _____

Do you have, or have you ever had any of the following?

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis (severe allergy)
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer/Tumors
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A, B, or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives and Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Sinus Trouble
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tuberculosis

Are you taking **ANY** prescription OR
ANY non-prescription medications? _____

_____

I certify that the information listed is complete and accurate.

X _____ Date _____
(PATIENT, PARENT, OR GUARDIAN)

Medical History Updates:

Date Comments

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____