Print Form

Next Page

Dental Questionnaire

PLEASE ANSWER ALL OF THE FOLLOWING CONFIDENTIAL HEALTH QUESTIONS COMPLETELY.

1. Please describe the primary reasons for your visit (concerns):
   1. _____
   2. _____

2. Have you come to this office for pain relief? ☐ Yes ☐ No

   If yes, how long has it hurt? _____

   Where is the pain? _____

   How does it hurt? With: Hot ☐ Yes ☐ No Sweets ☐ Yes ☐ No
   Cold ☐ Yes ☐ No Constantly ☐ Yes ☐ No

3. How long since you have been to a dentist? _____ Month(s) _____ Year(s)

4. When was the last set of full mouth x-rays? _____

5. How often do you brush your teeth? _____

6. Please check any items below that you use often in oral care:

Hand Tooth Brush	☐ Yes ☐ No	Gum Stimulators	☐ Yes ☐ No
Electric Tooth Brush	☐ Yes ☐ No	Rubber Tips	☐ Yes ☐ No
Dental Floss	☐ Yes ☐ No	Water Spray	☐ Yes ☐ No

7. Have you ever suffered from, or been told you may have any of the following:

Gum Disease	☐ Yes ☐ No	Malocclusion	☐ Yes ☐ No
Bruxism or Grinding	☐ Yes ☐ No	Bad Breadth	☐ Yes ☐ No
Jaw Pain or TMJ	☐ Yes ☐ No	Headaches or Migraines	☐ Yes ☐ No
Dental Pain	☐ Yes ☐ No	Extraction complication	☐ Yes ☐ No

8. If you could rate your smile from 1 - 10, what would it be? ☐

9 Would you like to improve your smile? ☐Yes ☐No How? _____

IF THIS IS FOR A NEW DENTURE, COMPLETE THE FOLLOWING PORTION:

10. When were your natural teeth removed? _____

11. How many sets of dentures have you had? ☐

12. When were your present dentures constructed? ☐

13 Do you like the appearance of your present set of dentures? ☐ Yes ☐ No

14. Has your present set of dentures ever been relined or rebased? ☐ Yes ☐ No

IF PATIENT IS CHILD, PLEASE ANSWER THE FOLLOWING QUESTIONS:

15. Please check any of the following habits the child has:

Thumbsucking	☐ Yes ☐ No	Nailbiting	☐ Yes ☐ No
Mouthbreathing	☐ Yes ☐ No	Unusual Speech Patterns	☐ Yes ☐ No

Next Page

Previous Page

Medical Questionnaire

1. Are you in good health? ☐ Yes ☐ No Date of your last physical examination?

2. Have you been a patient in the hospital in the last 3 years? ☐ Yes ☐ No

3. Are you now under the care of a physician? ☐ Yes ☐ No If yes, for what condition: _____

4. Have you been under the care of a medical doctor during the last 2 years? ☐ Yes ☐ No

Physician's Name: _____ Phone No.: _____

Physician Address: _____

5. Have you ever had a serious illness or operation? ☐ Yes ☐ No If yes, for what condition: _____

6. Are you now taking any medication or drugs? ☐ Yes ☐ No

If yes, please list: _____

7. Are you now taking any medication or drugs during the last 2 years? ☐ Yes ☐ No

8. Have you ever taken the drugs: ☐ Phen-Phen ☐ Redux or any diet drugs?

9. Are you sensitive or allergic to any medication or anesthetics? ☐ Yes ☐ No

If yes, please list: _____

10. Have you ever been premedicated with antibiotics for your dental treatment? ☐ Yes ☐ No

11. Indicate which of the following you have had or have at the present:

Heart Failure	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	A.I.D.S.	☐ Yes	☐ No
Heart Disease or Attack	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores / Fever Blisters	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Developmentally Disabled	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Allergy to Metal	☐ Yes	☐ No		☐ Yes	☐ No
Allergy to Latex	☐ Yes	☐ No	Hepatitis A or B or C	☐ Yes	☐ No		☐ Yes	☐ No
Artificial Joints (hip, etc.)	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No		☐ Yes	☐ No

12. Do you have or have you had any disease, condition, or problem not listed ? ☐ Yes ☐ No

If yes, please list: _____

13. Do you smoke? ☐ Yes ☐ No If yes, how much? ☐ Cigarettes ☐ Cigars Packs per day: ☐

CONSENT FOR TREATMENT: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health Questionnaire form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Patient Name: _____ Patient Signature: _____

Current Date: _____

Previous Page