Medical and Dental Questionnaire

Name_____ Date_____

Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth_____ S.S.#_____

Email Address_____ Employer_____

Whom may we thank for referring you to our office? _____

Medical History

Name and address of physician_____

Which medical conditions are you presently being treated for? _____

Have you been hospitalized or had major surgery? _____

If female: Are you pregnant or nursing? _____ Are you taking birth control or hormones? _____

Have you ever been told that you need pre-medication before a dental appointment? _____

Are you **allergic** to any medications or materials? _____

Please list any medications you are taking at this time _____

_____

Do you smoke? _____ Do you chew tobacco? _____

Please circle any condition you have a history of:

High blood pressure	Heart ailment	Artificial heart valve	Angina
Diabetes	Rheumatic fever	Heart Murmur	Asthma
Joint replacement	Mitral valve prolapse	Hepatitis	HIV positive
AIDS	Cancer	Epilepsy	Organ transplant
Thyroid	Psychiatric treatment	Herpes	Sinus/seasonal allergies
Glaucoma	Arthritis	Venereal disease	Drug dependency
Osteoporosis	Pacemaker	Prolonged bleeding	Sleep apnea

Other_____

Signature_____ Parent or Guardian

Dental Questionnaire

How may we help you? _____

What do you want your teeth/oral health to be like in 10 to 20 years? _____

_____

If we see something that will become a problem in the future would you like to know? _____

How do you feel about the appearance of your smile? _____
What would you improve about your smile? _____

We approach your oral health from three directions:

1) Mandatory—means addressing breaks, infection and cavities (the bare minimum approach)
2) Elective—means something that can be improved to prevent a future problem
3) Cosmetic—means anything that can improve the appearance of your smile

Which would you like to know more about? (Please check all that apply)
_____Mandatory _____Elective _____Cosmetic

Do your gums ever bleed? _____ When? _____

Are you aware that your gum health can easily place you at risk for a heart attack, stroke, the onset of diabetes, and preg
complications? _____ Does this info concern you? _____

Are you concerned about your health? _____ Why? _____

Do you experience frequent headaches or migraines presently? _____ In the past? _____
If so, do you wake up with a headache in the morning? _____

Has a headache limited your activities for a day or more in the last three months? _____

Are you aware that you clench or grind your teeth? _____ If so, when? _____

Do you ever experience tightness, soreness or discomfort in your cheek muscles? _____
Soreness or tightness above the shoulders? _____

Do you or your mate snore? _____ If so, who? _____

Do you feel well rested in the morning? _____ Do you routinely feel sleepy during the day? _____

If tired, please explain _____