

PATIENT

Last Name _____ First _____ Middle _____ Sex M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Soc. Sec. # _____ Date of Birth _____ Spouse _____

Work Phone _____ Marital Status _____ E-Mail _____

Cell Phone _____ Responsible Party _____ Relationship _____

In Case of Emergency Call _____ Relationship _____ Phone _____

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

Place of Employment _____ May we call you at work? YES NO

Physician Name _____ Phone _____ Date of Last Visit _____

Surgical Procedures Last 12 months _____

Current Medical Treatment _____

Current Medications (Rx, Vitamins, Supplements) _____

Pre Medicate YES NO (for: Heart Valve, Joints, implants) _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ?

- | | | | | | |
|-----|----|--|-----|----|---|
| YES | NO | HEART ATTACK, CHEST PAIN, ANGINA - NITRO TABS | YES | NO | DIABETES , DIET CONTROLLED, INSULIN |
| YES | NO | HEART MURMUR, MITRAL VALVE PROLAPSE (MVP) | YES | NO | CANCER: Type _____ Date _____ |
| YES | NO | RHEUMATIC HEART FEVER, ARTIFICIAL HEART VALVES | YES | NO | ARTHRITIS |
| YES | NO | HIGH or LOW BLOOD PRESSURE | YES | NO | KIDNEY DISEASE |
| YES | NO | BYPASS OR ANGIOPLASTY | YES | NO | SMOKER, EMPHYSEMA, C.O.P.D, ASTHMA |
| YES | NO | PACEMAKER | YES | NO | ULCERS, COLITIS, INTESTINAL DISORDERS |
| YES | NO | STROKE | YES | NO | HERPES or COLD SORES, CANKER SORES |
| YES | NO | ALLERGIES: PENICILLIN ERYTHROMYCIN LATEX | YES | NO | HIV OR AIDS |
| YES | NO | Other Allergies _____ | YES | NO | LIVER DISEASE, HEPATITIS A OR B OR C |
| YES | NO | ARTIFICIAL JOINTS: HIP KNEE OTHER | YES | NO | EPILEPSY OR SEIZURES |
| YES | NO | CURRENTLY PREGNANT, NURSING, BIRTH CONTROL | YES | NO | BLOOD TRANSFUSIONS, Hospitalized last 2 years |

Do you feel well ? YES NO Do you have any other disease, infection or medical condition that we should be aware of ? _____

Patient Signature or Guardian _____ Date _____

MEDICAL HISTORY

Questionnaire

Name _____ Date _____

These are things that are important to me about my dental health: (Please check one)

1. My mouth is very comfortable.
 My mouth is moderately comfortable.
 My mouth is uncomfortable.
2. I feel that the appearance of my mouth is very good.
 I am satisfied with the appearance of my mouth.
 I am dissatisfied with the appearance of my mouth.
3. I will do anything to keep my natural teeth.
 I want to keep my natural teeth, but have certain budgets of time and money I am willing to spend on them.
 I don't care whether I keep my teeth or not.
4. I have set goals for my oral health with a previous dentist.
 I want to set goals concerning my dental health.
 I am not interested in thinking about the future of my teeth at this time.
5. I have always completed the care that was recommended for my dental health.
 I have not done what dentists have recommended for my mouth.
 I rarely go to the dentist and only do what is necessary to be free of pain and cosmetic embarrassment.
6. I have put dentistry for myself and my family high on my priority list.
 I have put dentistry for myself and my family low on my priority list.
 I have put dentistry for myself and my family on my list but it is hard to find.
7. I think my present state of dental health is:
 Excellent.
 Average.
 Don't have a clue.
8. Should I require some form of treatment, the following best describes my feelings about the types of dental restorations that I would like in my mouth:
 I want the best restoration possible that will be the most conservative and give the longest life.
 I want all of the above and I want only tooth colored restorations, even though they may not be as durable and require more care and a greater investment.
 I want the least expensive restoration that will get me by for now.
9. Please select the single factor that best describes your reason for getting dental care. (Check only one.)
 Desire to avoid pain.
 Desire to look my best.
 Desire to intercept problems early and to avoid preventable expenses in the future.
 Desire to avoid dentures.
 Other _____
10. Please describe in the order of importance your concerns about your mouth now, as well as any questions that you have always wanted answered about your mouth: