Dental and Medical History Questionnaire

Name: ______________________ Date of Birth: ____/____/____ Gender: Male/ Female
Soc. Sec. # ______________ Marital Status ________
Address: ______________________ City: __________ State: ______ Zip Code ________
Home Phone: ______________________ Work Phone: ______________________
Cell Phone: ______________________ E-Mail Address: ______________________
How did you hear about our office? ______________________________________
Emergency contact: Name ______________ Relationship ________ Phone Number ________
Do you have any tooth pain today? Yes/No If yes, please explain: ______________________

PLEASE ANWSER THE FOLLOWING QUESTIONS					
Do you have any tooth pain?	Y	N	Do you have dry mouth or no saliva?	Y	N
Do you have problems chewing?	Y	N	Do you have heartburn, ulcers or reflux?	Y	N
Do you clench or grind?	Y	N	Are you happy with your smile?	Y	N

Do you smoke or use tobacco?

Y N
□ □

Females only:

Y N
□ □ Are you taking birth control?
□ □ Are you pregnant? If yes, number of weeks ________
□ □ Are you nursing?

Physician Name: **Physician Phone Number:**

Please list current medications: ______________________________________

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Y	N	CONDITIONS	Y	N	CONDITIONS	Y	N	
□	□	Abnormal bleeding	□	□	Hepatitis	□	□	any additional conditions not listed?
□	□	Allergies, seasonal	□	□	High Blood Pressure	If yes please list below:		
□	□	Antibiotics before dental treatment	□	□	Kidney Problems			
□	□	Artificial Heart Valve	□	□	Liver Disease			
□	□	Artificial Joint	□	□	Low Blood Pressure	**Y**	**N**	
□	□	Asthma	□	□	Organ Transplant	□	□	Parents does your child have special needs?
□	□	Taking Blood Thinners	□	□	Pace Maker			
□	□	Cancer-Chemotherapy	□	□	Pain in Jaw Joints			
□	□	Colitis	□	□	Psychiatric Problems			
□	□	Congenital Heart Defect	□	□	Radiation Therapy	**Y**	**N**	**Allergies to meds, etc.**
□	□	Diabetes	□	□	Rheumatic Fever	□	□	Aspirin
□	□	Difficulty Breathing	□	□	Seizures	□	□	Codeine
□	□	Drug Abuse	□	□	Shingles	□	□	Dental Anesthetics
□	□	Emphysema	□	□	Sickle Cell Disease	□	□	Erythromycin
□	□	Epilepsy	□	□	Sinus Problems	□	□	Jewelry
□	□	Fever Blisters	□	□	Stroke	□	□	Latex
□	□	Frequent Headaches	□	□	Thyroid Problems	□	□	Metals
□	□	Glaucoma	□	□	Tuberculosis	□	□	Penicillin
□	□	HIV or AIDS	□	□	Ulcers	□	□	Tetracycline
□	□	Heart Attack	□	□	Venereal Disease	Other:		