CONTEMPORARY DENTAL HEALTH QUESTIONNAIRE

Name:_____

Date of Birth:_____

Chief Complaint (Why are you seeking dental care?)_____

Current State of Health
Are you in good health?..... YES NO
Are you currently under the care of a physician?.....YES NO

Please list your family physician and any medical specialists you see at least once a year: (please print)

Name	address	city	phone #	name of specialty

Circle Below **MEDICAL HISTORY**

1. Do you have (or have you ever had) any of the following?

YES NO a. allergic reaction to drugs or latex (circle all that apply)

Latex Penicillin Aspirin Codeine Dental Anesthetics other

YES NO b. heart attack or heart disease
YES NO c. stroke
YES NO d. high blood pressure
YES NO e. congestive heart failure
YES NO f. angina (chest pains)
YES NO g. irregular heart beat
YES NO h. artificial heart valve
YES NO i. rheumatic fever, rheumatic heart disease, bacterial endocarditis
YES NO j. congenital heart disease
YES NO k. heart murmur or mitral valve prolapse
YES NO l. Immunosuppressive condition (Circle all that apply)

Steriod therapy (e.g. prednisone) Radiation or Cancer Therapy SLE (Lupus)

Rheumatoid Arthritis HIV Organ Transplant Spleen Removed other

YES NO m. artificial joint(s) (Circle all that apply)

HIP KNEE ANKLE Shoulder
Date(s) placed:

YES NO n. other artificial implants or devices

YES NO o. bleeding problem, anemia, other blood diseases

YES NO p. diabetes

YES NO q. thyroid disease
YES NO r. long term antibiotic use (greater than one month continuously)
YES NO s nervous system disease or seizures
YES NO t. kidney disease
YES NO u. hepatitis (A, B, C or D) or other liver disease
YES NO v. muscle or joint disease or arthritis (osteo or rheumatoid)
YES NO w. asthma, tuberculosis , or other lung disease
YES NO x. stomach or intestinal disease
YES NO y. mental health condition- specify_____
YES NO z. physical or mental disabilities that may require special care?
YES NO aa. Impairment of hearing, sight or speech
YES NO
YES NO bb. Do you have or have you ever been treated for cancer?

YES NO 2. Are you or could you be pregnant? Are you nursing? _____

YES NO 3. Do you have any disease, condition, or problem not listed here?
Describe:

YES NO 4. Have you ever been hospitalized or had surgery?
Describe:

YES NO 5. Do you have undiagnosed symptoms?
Describe:

YES NO 6. Are you, or have you ever been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)
YES NO 7. Do you currently drink alcohol or use recreational drugs?
YES NO 8. Do you smoke or use smokeless tobacco?
9. What type of tobacco product(s) do you use?_____
10. How interested are you in stopping your tobacco use? (circle one)
Very interested somewhat interested not at all interested
YES NO 11. Do you regularly take herbal medicines or dietary supplements?
Specifically, do you take (circle all that apply):

Echinacea Garlic Ginger Kava Valerian

Feverfew Gingko Ginseng St. Johns wort Vitamin E

YES NO 12. Have you undergone current or past osteoporosis therapy?
(Examples are: Fosomax, Actonel, Boniva pill form, Reclast)
YES NO 13. Have your undergone current or past therapy to reduce high blood calcium
(biphosphonate therapy)? (examples are: intravenousAredia, Zometa)

DENTAL HISTORY

YES NO 14. Do you have regular dental check-ups? Date of last exam:_____
YES NO 15. Have you had any trouble associated with previous dental treatment?
If so, please explain:_____

YES NO 16. Have you noticed any lumps or sores in your mouth?
YES NO 17. Do your gums bleed when you brush your teeth?
YES NO 18. Have you ever injured your face, jaws, or teeth?
YES NO 19. Do you suffer any pain in the mouth, face, eyes, neck, or throat?
YES NO 20. Are you happy with the appearance of your teeth?
YES NO 21. Do you want to save your teeth?
YES NO 22. Has fear ever prevented you from seeking dental treatment?
YES NO 23. Are you allergic to any metals or dental materials?
24. Circle the types of dental treatment you have experienced:

Orthodontics (braces) Dentures Root Canal treatment implants

Oral Surgery Periodontal (gums) treatment TMJ treatment Fillings

MEDICATIONS

Please list all medication you are currently taking:

_____

_____

_____

Pharmacy Name: _____
Phone Number: _____

By signing below, you agree that the information given is accurate and that you will notify our office at subsequent appointments if there is any changes in you health.

Patient Signature: _____ Date: _____
(0r) Patient's representative:_____ relationship to patient:_____

Doctors Signature :_____Date:_____