DENTAL AND HEALTH QUESTIONNAIRE

Patient's First Name____________________**Patient's Last Name**______________________________
Height________________________________**Weight**____

Family Dentist____
Frequency and type of dental care____
Have you had previous periodontal care? ☐Yes ☐No
If yes, when and by whom?

____
Have you ever had orthodontic treatment? ☐Yes ☐No
If yes, when and by whom?____

Do you have or have you experienced any of the following?

- Abscesses
- Bad taste/breath
- Bleeding Gums
- Discomfort
- Floss Snagging
- Food Impaction
- Recent Tooth Loss
- Sensitivity to Biting
- Pressure
- Loose Teeth
- Spontaneous Tooth Movement

Do you use: ☐Gum ☐Coffee ☐Soft Drinks ☐Tea ☐Breath Mints
Is your toothbrush: Hard ☐Medium ☐Soft

Does your M.D. require you to pre-medicate with antibiotics prior to all dental procedures? ☐Yes ☐No
If yes, why? ____

Are you allergic to any medications or drugs, Latex, Iodine? ☐Yes ☐No
If yes, please list____

Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)? ☐Yes ☐No
If yes, please list____

Have there been any changes in your general health in the past year? ☐Yes ☐No

Have you had a serious illness, operation or hospitalization within the past five years? ☐Yes ☐No
If yes, please describe____

Are you taking or have you recently taken prescribed medications, inhalers, over the counter natural or herbal preparations? ☐Yes ☐No
If yes, please list____

Have you ever taken or been treated with bisphosphonates (medications to treat bone loss) of any kind? ☐Yes ☐No
If yes, what and how long? ____

Have you ever had excessive bleeding that required special treatment? ☐Yes ☐No

Is there a history of Diabetes in your family? ☐Yes ☐No

Do you use any kind of tobacco? ☐Yes ☐No
If yes, how much: per day, week, month____

Do you use any kind of alcohol? ☐Yes ☐No
If yes, how much: per day, week, month____

Do you have any history of substance abuse or do you currently use recreational drugs? ☐Yes ☐No

HEALTH QUESTIONNAIRE

Choose all of the following that you may have had in the past or that currently apply to you:

CARDIOVASCULAR
o Chest Pain Upon Exertion
o Shortness of Breath
o High Blood Pressure
o Low Blood Pressure
o Heart Valve Prosthesis
o Mitral Valve Prolapse
o Congenital Heart Lesion
o Rheumatic Fever
o Heart Murmur
o Damaged Heart Valve
o Heart Arrhythmia
o Tachycardia
o Heart Surgery
o Cardiac Pacemaker

NEUROLOGIC/PSYCH
o Seizures/Epilepsy
o Stroke
o Migraines
o Depression/Anxiety
o Mental Health Problems

EYE
o Cataracts
o Glaucoma
o Wear Contact Lenses
o Severely Impaired Vision

KIDNEY
o Kidney Disease
o Impaired Kidney Function
o Hemodialysis

PULMONARY
o Asthma
o Emphysema
o Tuberculosis

GENERAL
o AIDS/HIV+
o Alcoholism
o Anorexia or Bulimia
o ARC
o Arthritis
o Blood Transfusions
o Cancer
o Chemotherapy
o Chronic Fatigue
o Cold Sores
o Connective Tissue Disorder
o Diabetes
o G.I. Ulcers
o Hepatitis
o Impaired Liver Function
o Irritable Bowel Syndrome
o Jaundice
o Joint Replacement Surgery
o Osteoporosis
o Persistent Cough
o Radiation Therapy
o Recurrent Infections
o Recent Weight Loss
o Sinus Trouble
o Sleep Apnea
o Substance Abuse
o Systemic Lupus

Do you have any disease, problem or condition not listed above?
*Please explain*____
____

Are you required, due to health, to restrict your work or activity in any way? ♉Yes ♉No

For women check all that apply: ♉ I am pregnant ♉ I am nursing ♉ I am taking birth control pills

Have you experienced an unusual reaction to *any* of the following?
o Anaprox
o Aspirin
o Codeine
o Erythromycin
o Iodine
o Latex
o Nitrous Oxide
o Penicillin
o Percodan
o Sulfa
o Synalgos
o Tetracycline
o Tylenol
o Valium
o Vicodin

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I accept the courtesy Dr. Peavy's office offers in submitting insurance claims on my behalf. I hereby authorize the release of any information relating to said claims. Moreover, I understand that this filing is done as a courtesy, and that I am responsible for all cost of dental treatments.

Patient Signature____Date_________________________