

Other Information

Date of Last Dental Visit: _____

MEDICAL QUESTIONS

What is your blood pressure? _____

Who is your physician? _____

Have you ever been hospitalized? _____

If yes, please explain. _____

Do you have a medical condition we need to be aware of? _____

If yes, please explain: _____

Do you currently/have you experienced headaches, migraines, vision or hearing problems? _____

If yes, please explain. _____

Have/are experiencing phlebitis, varicose veins, blood clots, high/low BP? _____

If yes, please explain. _____

Have/are you experiencing any numbness, tingling, muscle pain? _____

If yes, please explain. _____

Are you experiencing any back pain, upper, mid, lower, sciatica? _____

If yes, please explain. _____

Have/are you experiencing tension, stress, depression, sleep difficulties? _____

If yes, please explain. _____

Are you currently taking any prescription medications? _____

If yes, for what conditions? _____

Have you been treated for heart, kidney, liver or blood borne diseases? _____

If yes, please explain. _____

Have you ever been treated for cancer of any type? _____

If yes, please explain. _____

Are you HIV+? _____

If yes, please explain. _____

Are you allergic to Penicillin,Aspirin,Codeine,Metal,Local Anesthetics,Acrylic,Latex _____

If yes, or have any other allergies please explain. _____

Females: Are you pregnant? _____

If yes, how many months? _____

DENTAL QUESTIONS

Have you experienced injuries to face, head, jaw or TMJ? _____

If yes, please explain. _____

Do you have a chief dental complaint today? _____

If yes, please explain. _____

Have you ever had a problem during a dental procedure? _____

If yes, please explain. _____

Are your teeth sensitive to sweets? Temperature? _____

If yes, please explain. _____

Do your gums bleed or have pain? _____

If yes, please explain. _____

Have you had any teeth removed? _____

If yes, please explain. _____

When was your last professional cleaning? _____

Do you have oral habits (biting nails,smoking,clenching your teeth)? _____

If yes, please explain. _____

Do you like the color of your teeth? _____

If yes, please explain. _____

Is there anything you would like to change about your smile? _____

If yes, please explain. _____

What is the most important thing about the relationship you have with your dentist?
