Tillman Family Dental DMD PC

Health Questionnaire

Patient Name: ____

How did you hear about this clinic?
- ❑ Family/Friend ________________
- ❑ Internet Search
- ❑ Insurance Company
- ❑ Website

Music Preference __________________

Purpose of Dental Visit:

- Chief complaint ____
- Personal Dental Goals____

DENTAL HISTORY

- Frequency of visits to the dentist? ______________ Types of care received? _________________________
- Difficulties with past treatment? Y or N
- Date of most recent x-rays?
- History of oral-facial injuries (date, type of injury, cause)? ____
- History of TMJ (temporomandibular joint) discomfort/pain/popping/grinding? __________________________
(date, type of problem, cause)? ____
- Do you have: Dry mouth _____ Bleeding gums _____ Dentures/Partials _____ Braces ______ Sores _____

MEDICAL HISTORY (past and present)

- Are you now or have you been under the care of a physician during the last 12 months? Y or N
  - For what purpose?_________________________________
  - Last time at physician?______________________________
- Physician's Name? ____ Physician's phone number_________________

SURGERY/HOSPITALIZATIONS: (date and type of surgery including appendix, tonsils, cosmetic)?
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____

____

ALLERGIES TO MEDICATIONS: (describe reaction, end result)?
____

____

MEDICATIONS: (dosage, dosage interval, route, including vitamins)

____________________________ ___________________________________ __________________________________

____________________________ ___________________________________ __________________________________

____________________________ ___________________________________ __________________________________

____________________________ ___________________________________ __________________________________

____________________________ ___________________________________ __________________________________

Females Only: Do you take oral contraceptives? Y or N Are you pregnant (if so, how many months)? _________

FAMILY HISTORY: Do you have or had any biological relatives with any medical condition (diabetes, high blood pressure, seizures, bleeding problems, cancer, other)? ____

____

SOCIAL HISTORY: Do you use now or have you used any street or recreation drug, tobacco, or consume alcohol (type, amount, frequency)? ____

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Review of Systems: **Patient Name:**____

Do you now have or have you had any of the conditions listed?

Cardiac
- ❑ Shortness of breath
- ❑ Pain, pressure in chest
- ❑ Heart attack
- ❑ Swelling of ankles
- ❑ High, low blood pressure
- ❑ Rheumatic, scarlet fever
- ❑ Heart Murmur
- ❑ Heart valve prolapse
- ❑ Irregular heart beat
- ❑ Prosthetic valves/pacemaker

Neurological
- ❑ Seizure
- ❑ Paresthesia, numbness
- ❑ Paralysis
- ❑ Stroke

Respiratory
- ❑ Cough, blood in sputum
- ❑ Bronchitis, emphysema
- ❑ Wheezing, asthma
- ❑ Tuberculosis, exposure to

Gastrointestinal
- ❑ Difficulty swallowing, chewing
- ❑ PUD, GERD
- ❑ Jaundice, hepatitis
- ❑ Liver Disease

Eyes
- ❑ Blurring of vision
- ❑ Double vision
- ❑ Drooping of eyelid
- ❑ Glaucoma

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Other

Endocrine
- ❑ Thyroid trouble
- ❑ Diabetes
- ❑ Excessive thirst

Genitourinary
- ❑ Difficulty, pain on urination
- ❑ Blood in urination
- ❑ Excessive urination
- ❑ Kidney Problems
- ❑ Sexually transmitted diseases

Hematopoietic
- ❑ Easy bruising, excessive bleeding
- ❑ HIV infection, AIDS
- ❑ Leukemia, problems with immune system
- ❑ Spleen problems

Ear, Nose & Throat
- ❑ Sinusitis
- ❑ Frequent sore throat

Skin
- ❑ Itching
- ❑ Rash
- ❑ Ulcers
- ❑ Pigmentation

Extremeties
- ❑ Prosthetic joints

location: ____________________

Growth or Tumor
- ❑ Radiotherapy
- ❑ Chemotherapy

Other

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____

I certify that I have answered all of the questions on this two page form and I have answered these questions truthfully and completely. I understand that not answering the questionnaire completely may result in serious complications with my overall health and/or dental treatment. I will not hold the dental clinic, the dentist, or any member of the dental staff responsible for any errors or omissions that I have made. In other words, I assume full responsibility for the accuracy of this questionnaire. I give my permission to discuss any portion of my medical history with my physician and/or pharmacist.

____ ______________

Signature of Patient or Guardian Date