NEVINS DENTAL CENTER
Implant & Esthetic Dentistry

HEALTH QUESTIONNAIRE

Your Full Name: Mr., Ms., Mrs., Miss, Dr. _____

Date of Birth _____ □ Single □ Married □ Divorced □ Widowed

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

City _____ State _____ Zip _____

Social Security # _____ Dental Insurance _____

Email _____ Cell Phone _____

Family Dentist's Name _____ How long? _____

Physician's Name _____ How long? _____

Whom may we thank for referring you to our office? _____

Please answer the following accurately and completely. The diagnosis and treatment of your condition depends on the identification of every possible contributing factor. Although some of the questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health.

MEDICAL HISTORY

	YES	NO
Are you in good health?	☐	☐
Have there been any changes in your general health?	☐	☐
Have you gained or lost weight in recent months? If so, how much? _____		
Have you had any serious illnesses or operations?	☐	☐
Please explain: _____		
Date of last physical exam? _____		
Are you under the care of a physician?	☐	☐
If so, for what? _____		
Are you presently taking any drugs or medications?	☐	☐
List: _____		
Are you taking or have you ever taken bisphosphonate medications?	☐	☐

Have you had any of the following conditions?

- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Abnormal blood pressure
- ☐ Stroke
- ☐ Congenital heart disease
- ☐ Anemia
- ☐ Blood disorders
- ☐ Heart murmur
- ☐ Nervous disorders
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Asthma/Hay fever
- ☐ Sinus trouble
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Jaundice or liver involvement
- ☐ Tuberculosis or lung disease
- ☐ AIDS, ARC or HIV+
- ☐ Thyroid condition
- ☐ Venereal disease
- ☐ Mitral valve prolapse

Are you **unable** to take any of the following drugs?

- ☐ Local anesthesia ("Novocaine")
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Other Drugs:

(list) _____

_____

	YES	NO
Have you ever had abnormal bleeding following dental extractions, surgery, or a cut?	☐	☐
Have you ever had radiation treatment for a tumor or skin disease?	☐	☐
Has any blood relative ever had diabetes?	☐	☐
Do you have frequent severe headaches?	☐	☐
Do you have chronic sores or boils of any kind on your skin?	☐	☐
Do you get short of breath after climbing on flight of stairs?	☐	☐
So your ankles swell during the day?	☐	☐
Do you get pains in your chest over your heart?	☐	☐
Have you been exposed to the HIV virus?	☐	☐
Do you have night sweats?	☐	☐
Have you ever used intravenous drugs?	☐	☐
Do you have swollen lymph nodes?	☐	☐
Have you ever had a blood transfusion?	☐	☐

Do you smoke?_____ How much? _____

Do you drink alcohol?_____ How much? _____

WOMEN ONLY

Are you pregnant?	☐	☐
Are you taking birth control?	☐	☐
Have you reached menopause?	☐	☐
Are you taking hormones?	☐	☐

DENTAL HISTORY

What is your present dental problem? _____

_____

Have you ever had a serious problem associated with previous dental treatment?	☐	☐

If so, where?_____

Are your teeth sensitive to cold, hot, or sweets?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do your jaws ache when you awaken in the morning?	☐	☐
Have you noticed any loose or shifting teeth?	☐	☐
Do you feel that you chew satisfactorily?	☐	☐
When you chew, do you have cracking, popping, or pain in the jaw joints?	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐
Have you had orthodontic therapy (braces)?	☐	☐
Do your gums bleed?	☐	☐
Have you noticed any mouth odor or bad taste?	☐	☐
Do you ever have blisters or cold sores on your lips?	☐	☐
Have you had prior periodontal therapy?	☐	☐

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature Date