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609-924-1234

PRINCETON CENTER FOR IMPLANT DENTISTRY
IMPLANT SURGERY, DENTAL & IMPLANT RECONSTRUCTION, COSMETIC DENTISTRY

HEALTH QUESTIONNAIRE

(CONFIDENTIAL INFORMATION FOR OUR FILES)

Date _____ Social Security #_____

Name_____ Age_____ Birth Date_____
LAST NAME MR.-MRS.-MISS-MS. FIRST NAME NICKNAME

Address_____ Home Phone ( ) _____
STREET CITY STATE ZIP

Business Address_____

Business Phone ( ) _____ Employed By_____ Occupation _____

E-mail Address_____ Cell Phone ( ) _____

Marital Status_____ Spouse's Name_____ Business Phone ( ) _____

Referred by _____ Dental Insurance Company _____

Name and Address of Previous Dentist _____

If you are completing this form for another person, what is your relationship to that person? _____

My major dental problem or reason for seeking treatment is: _____

_____

_____

In the following questions circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Do you need to Pre-Medicate before a dental visit ..... YES NO

1. Has there been any change in your general health within the past year?..... YES NO
2. My last physical examination was on .....
3. Are you now under the care of a physician? ..... YES NO
4. The name and address of my physician.....
.....
5. Have you had any serious illness or operation? ..... YES NO
   If so, what was the illness or operation? .....
   .....
6. Have you been hospitalized or had a serious illness within the past (5) years? ..... YES NO
   If so, what was the problem?.....
   .....

Do you have or have you had any of the following diseases or problems?

7. Rheumatic fever, rheumatic heart diseases, mitral valve prolapse or heart murmer.
   ..... YES NO
8. Congenital heart lesions..... YES NO
9. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... YES NO
10. Pain in chest upon exertion? ..... YES NO
11. Shortness of breath after mild exercise?..... YES NO
12. Swollen ankles? ..... YES NO
13. Shortness of breath when you lie down or do you require extra pillows when you sleep?..... YES NO
14. Cardiac pacemaker? ..... YES NO
15. Allergy..... YES NO
16. Sinus trouble..... YES NO
17. Asthma or hay fever..... YES NO
18. Hives or skin rash..... YES NO
19. Fainting spells or seizures ..... YES NO
20. Diabetes..... YES NO
    a. Do you have to urinate (pass water) more than six times a day?..... YES NO
    b. Are you thirsty much of the time?..... YES NO
    c. Does your mouth frequently become dry?..... YES NO
21. Hepatitis, jaundice or liver disease..... YES NO
22. Arthritis..... YES NO
23. Inflammatory rheumatism (painful swollen joints) ..... YES NO
24. Stomach ulcers..... YES NO
25. Kidney trouble..... YES NO
26. Tuberculosis..... YES NO
27. Persistent cough or cough up blood ..... YES NO
28. Low blood pressure..... YES NO
29. Herpes, venereal disease, gonorrhea, syphilis, ... YES NO
30. Abnormal bleeding associated with previous extractions, surgery or trauma YES NO
31. Bruise easily..... YES NO
32. Blood transfusion..... YES NO
    If so, explain the circumstances.....
33. Blood disorder such as anemia ..... YES NO
34. Surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips..... YES NO
35. A loss or gain of 10 pounds or more in the past year ..... YES NO
36. Persistent diarrhea ..... YES NO
37. AIDS, ARC or positive antibody test to HIV/HTLV-III..... YES NO
38. Psychiatric therapy ..... YES NO
39. Thyroid disease ..... YES NO
40. Artificial bones or joints (prosthesis) implanted..... YES NO
41. Have you ever been denied permission to give blood? ..... YES NO

42. Hearing, visual problems or other disabilities which we should consider in planning your dental treatment (e.g. glaucoma) ..... YES NO
43. Have you ever been in contact with any individual having hepatitis, tuberculosis or AIDS? ..... YES NO
44. Are you addicted or recovering from any drugs or alcohol? ..... YES NO
45. Cancer ..... YES NO
46. Problems of the immune system ..... YES NO
47. Are you taking any drug or medicine ..... YES NO
    If so, what .....
    .....
48. Are you taking any of the following:
    a. Anticoagulants (blood thinners) ..... YES NO
    b. Medicine for high blood pressure ..... YES NO
    c. Cortisone (steroids) ..... YES NO
    d. Tranquilizers ..... YES NO
    e. Antihistamines ..... YES NO
    f. Aspirin ..... YES NO
    g. Insulin, tolbutamide (Orinase) or a similar drug ..... YES NO
    h. Digitalis or drugs for heart trouble ..... YES NO
    i. Nitroglycerin ..... YES NO
    j. M.A.O. inhibitors ..... YES NO

49. Are you allergic or have you reacted adversely to:
    a. Local anesthetics ..... YES NO
    b. Penicillin or other antibiotics ..... YES NO
    c. Sulfa drugs ..... YES NO
    d. Barbiturates, sedatives, or sleeping pills ..... YES NO
    e. Aspirin ..... YES NO
    f. Iodine ..... YES NO
    g. Codeine or other narcotics ..... YES NO
    h. Latex ..... YES NO
    i. Other .....
50. Do you have any disease, condition or problem not listed above that you think I should know about? ..... YES NO
    If so, explain .....

Women

51. Are you pregnant, or anticipating pregnancy in the near future? ..... YES NO
52. Do you have any problems associated with your menstrual period? ..... YES NO
53. Are you nursing? ..... YES NO
54. Taking birth control pills? ..... YES NO
55. Are you taking any hormones? ..... YES NO
56. Are you taking/have you taken Bisphosphonates (oral or IV)? ..... YES NO
    (any medication for Osteoporosis or Osteopenia)

Dental History

56. Are you having any discomfort at this time? ..... YES NO
57. Are you presently seeing any dental specialist? ..... YES NO
58. When was your last visit to the dentist? .....
59. When was your most recent x-ray and where? .....
    .....
60. Do you have any missing teeth? ..... YES NO
61. Have they been replaced? ..... YES NO
62. Are your teeth sensitive? ..... YES NO
    If so, circle any that apply: Heat Cold Sweets Chewing
63. Do you have a history of fever blisters or "cold sores"? ..... YES NO
64. Do you have recurrent canker sores, mouth ulcers or oral herpes infections? ..... YES NO
65. Do you have a dry mouth frequently? ..... YES NO
66. Have you ever had an unpleasant experience or any serious trouble associated with any previous dental treatment? ..... YES NO
    Explain: .....

67. Do your gums ever bleed? ..... YES NO
68. Do you grind or clench your teeth? ..... YES NO
69. Does food ever get wedged between your teeth? ..... YES NO
70. Does your jaw ever pop, click or hurt? ..... YES NO
71. Do you ever have headaches? ..... YES NO
72. Have you ever had any of the following? (circle)
    Gum treatment Braces Oral Surgery
    Explain: .....
73. Do you feel you may have bad breath or a bad taste in your mouth? ..... YES NO
74. Do you smoke cigarettes? ..... YES NO
75. Do you drink alcoholic beverages? ..... YES NO
76. Do you have any fear of dentistry? ..... YES NO
77. Do you have any disease condition or problem not listed? ..... YES NO
    If yes, please specify: .....
    .....

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____

I understand that an appointment for any dental treatment is considered to be time reserved with the doctor or the doctors' staff. I understand that I must give at least 24 hours or one business day advance notice to cancel or change an appointment or a charge will be made for the time reserved.

Signature of Patient: _____

For Completion by the dentist

Comments on medical history and patient medications: _____

_____

_____

Dental management considerations: _____

Date: _____ Signature of Dentist: _____