HEALTH QUESTIONNAIRE

Winston-Salem Dental Care

PATIENT LAST NAME _____ FIRST _____ INITIAL _____

DATE OF BIRTH _____ PATIENT CHART NUMBER _____ DATE _____

Kenneth M. Sadler, DDS and Associates, P.A.

Medical History

	YES	NO
1. Have you been treated by a physician or been in the hospital in the past year?		
2. Has there been any changes in your general health in the past year?		

Date of last medical exam: _____

Name and address of Medical Doctor: _____

3. List all medications, drugs, supplements you are taking at this present time?

Medication and Supplements/ Reasons	Medication and Supplements/ Reasons

4. **Circle** all that applies:

Do you have any of the following: Please explain to your dental professional

Allergies or sensitivity to Medications	yes	no	Herpes	yes	no
Allergies or senstivity to Latex	yes	no	Headaches or Migraines	yes	no
Allergies or sensitivity to foods or metals	yes	no	Hemophilia, Bleeding disorders, or Sickle Cell	yes	no
Anemic	yes	no	Hepatitis, if so what type	yes	no
Arthritis	yes	no	High or Low Blood Pressure	yes	no
Artifical joint replacement, if so where and when?	yes	no	HIV Infection or AIDS	yes	no
Asthma	yes	no	Immunosuppressive Therapy	yes	no
Blood disorder or taking a blood thinner	yes	no	Implants, if so where and when?	yes	no
Bone or joint issues	yes	no	Kidney or Bladder disease	yes	no
Breathing issues, if so explain	yes	no	Liver disorder	yes	no
Cancer, if so what type	yes	no	Osteoporsosis -have taken or	yes	no
Chemotherapy	yes	no	taking bone building medication	yes	no
Congential Heart Defect	yes	no	Pacemaker	yes	no
COPD	yes	no	Psychiatric Care	yes	no
Diabetes , if so what type	yes	no	Radiation Therapy	yes	no
Defibrillator	yes	no	Rheumatic Fever	yes	no
Emphysema	yes	no	Seasonal Allergies	yes	no
Epilesy or Seizures	yes	no	Sinus problems	yes	no
Eye diseases	yes	no	Stomach reflux or ulcers	yes	no
Eyewear or contacts	yes	no	Shunts	yes	no
Gastric By-Pass Surgery	yes	no	Stroke	yes	no
Glaucoma	yes	no	TB (tuberculosis)	yes	no
Hearing disability	yes	no	Thyroid Disease	yes	no
Heart Attack or Coronary disease	yes	no	Tumors	yes	no
Heart Murmur	yes	no	Weight loss or gain issues?	yes	no
Heart Surgery	yes	no	Other: _____		
Heart Valve Replacement	yes	no	_____		

	YES	NO
5. Are you pregnant or nursing?, if so what trimester? _____		
6. Do you use or have used tobacco products?		
7. Do you use or have used recreational drugs?		
8. Do you consume alcohol?		

9. Any other medical information? Please explain _____

_____

10. Have you traveled out of the country in the last month? If so, where? _____

HEALTH QUESTIONNAIRE

Dental History **YES** **NO**

11. Have you been to a Dentist before? _____ _____
    Name and address of previous Dentist? _____
    _____
12. Have you been to a Dentist in the past year? Why? _____
13. Have you had X-rays taken of your teeth? If so, when? _____ _____
14. Have you had any reaction to dental treatments? If so, what and when? _____
15. Do you have any dental implants? If so, where and when were they placed? _____
16. Do you have your natural teeth? _____ _____
17. Are you having any dental problems today? If so, where? _____
18. Are you in dental pain or have severe toothaches? If so, where? _____
19. How many times a day do you brush and/or floss your teeth? brush _____ floss _____
20. Has anyone (Dentist, Hygienist, Nurse, or Physician) ever shown you how to clean your teeth? _____ _____
21. Have you ever had any treatment for your gums? If so, when and where? _____ _____
22. Do your gums bleed or hurt when you brush them? _____ _____
23. Are you satisfied with the appearance of your teeth? _____ _____
24. Do your teeth feel loose? If so, where _____ _____ _____
25. Have you been aware of any bad odor or taste in your mouth? _____ _____
26. Are you teeth sensitive to heat, cold, or sweets? If so, where _____ _____
27. Do your teeth hurt when you chew? If so, where _____ _____
28. Do you clamp, clench, or grind your teeth during the night or day? _____ _____
29. Do you have any jaw tenderness? Have you ever had a jaw injury? _____ _____
30. Do have any other tooth, gum, or jaw problems that you would like to discuss? _____ _____
31. Have you ever had a traumatic dental experience? _____ _____
32. Have you ever had orthodontic treatment or worn braces? _____ _____
33. Have you had your wisdom teeth extracted? _____ _____
34. Have you had any bisphosphonate or bone building therapies? _____ _____
35. Have you ever received Nitrous Oxide, Oral or IV sedation for dental therapy? _____ _____
36. Have you had any complications or illness following dental treatment? _____ _____
37. Do you use a power assisted toothbrush? _____ _____
38. Do you use fluoride mouth rinses? _____ _____
39. Do you use any mouthwashes? _____ _____
40. Do you want to discuss any other dental issues? _____ _____

_____
_____

TO THE BEST OF MY KNOWLEDGE, THE FOREGOING QUESTIONS HAVE BEEN ACCURATELY ANSWEREI

SIGNATURE _____
(If a minor, parent or guardian signature requirec date

DENTIST SIGNATURE _____

KS/thz 7/16 date