gentle dental Clinic Crete

Name:_____Date: _____

Date of Birth_____ Age:_____

Write Yes/No

1. Have you been hospitalized or under the care of a physician with the last 2 years?_____

2. Has there been a change in your general health within the past 2 years?_____

3. Are you allergic to penicillin or any other drugs?_____

4. Indicate **Yes** or **No** to any of the conditions below for which you are being treated or you have had:

Y / N Heart attack Y / N Heart trouble Y / N Heart surgery Y / N chest pain Y / N High blood pressure Y / N Prolapsed mitral valve Y / N Heart murmur Y / N Artificial heart valves Y / N Congenital heart lesions Y / N Cardiac pacemaker Y / N Rheumatic fever Y / N Stroke	Y / N Allergies Y / N Hives, skin rash Y / N Cancer treatment Y / N Radiation therapy Y / N Ulcers Y / N Gastritis Y / N Hiatus hernia Y / N Easy bruising Y / N Excessive bleeding Y / N Artificial joint Y / N Arthritis Y / N Asthma Y / N Persistent cough	Y / N Emphysema Y / N Substance abuse Y / N AIDS Y / N HIV infection Y / N Diabetes Y / N Hepatitis Y / N Kidney trouble Y / N Psychiatric treatment Y / N Fainting spells Y / N Seizures Y / N Epilepsy Y / N Anemia

Women only

Y / N Currently pregnant Y / N Nursing Y / N Female problems

Do you use tobacco? Y / N How much?_____

Do you drink alcohol? Y / N Type?How much?_____

5. Have you had any serious illness, disease, or condition not listed above?

If so,explain _____

_____

_____

6. Indicate date of your last physical examination_____

7. Name and telephone number of your personal physician

_____

_____

8. List any medications you are currently taking

_____

_____

9. Have you had any problems or anxiety associated with previous dental care? If so,explain

_____
_____
_____

DENTAL QUESTIONNAIRE

Indicate Yes or No to the following:

Y / N 10. Does it hurt when you chew?
Y / N 11. Is a tooth sensitive or tender?
Y / N 12. Do you have frequent toothaches or gum pain?
Y / N 13. Do your gums bleed a lot when you brush your teeth?
Y / N 14. Do you have occasional dryness or burning in your mouth?
Y / N 15. Do you have occasional pain in the jaws, neck, or temples?
Y / N 16. Does it hurt when you open wide or take a big bite?
Y / N 17. Does your jaw make "clicking or popping" sounds when you chew or move your jaw?
Y / N 18. Do you suffer from headaches?
Y / N 19. Do you have occasional ear pain or pain in front of the ears?
Y / N 20. Does your jaw "feel tired" after a meal?
Y / N 21. Do you ever have to search for a place to close your teeth?
Y / N 22. Does a tooth ever get in the way?

23. Is there anything you wish to tell us that has not been asked?

_____
_____

24. Were there any items you did not understand?

_____
_____

I will inform the Clinic of any changes in the above

Person completing form sign here:

Date signed: