This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible.

PATIENT INFORMATION TODAY'S DATE: ________________

☐MR. ☐MS ☐MISS ☐MRS. ☐DR. Name: ____
FIRST MIDDLE INITIAL LAST

AGE: ________________ DATE OF BIRTH: ______________________ ☐MALE ☐FEMALE

ADDRESS:_________________________________ CITY/STATE/ZIP: _____________________

E-MAIL ADDRESS: ____

MOBILE TELEPHONE NUMBER: ____

HOW LONG AT CURRENT ADDRESS? __________ (IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.)

PREVIOUS ADDRESS: ____

EMPLOYED BY: _________________________________OCCUPATION: __________________

ADDRESS: ____

REFERRED BY: ____

SS#: ________________HOME PHONE: ______________WORK PHONE: _________________

ADDRESS IF DIFFERENT FROM PATIENT: ____

FAMILY PHYSICIAN: ____

ADDRESS: ____

FAMILY DENTIST/Previous Dentist: ____

ADDRESS: ____

CENTER FOR Complete Dentistry

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

- Y ☐ N ☐ Diet limited to semisolid or soft foods
- Y ☐ N ☐ Mouth sores
- Y ☐ N ☐ Diet limited to liquid foods
- Y ☐ N ☐ Numbness in lower lip
- Y ☐ N ☐ Difficulty chewing
- Y ☐ N ☐ Numbness in jawbone
- Y ☐ N ☐ Difficulty speaking
- Y ☐ N ☐ Tingling in jawbone
- Y ☐ N ☐ Nutritional disorders
- Y ☐ N ☐ Digestive problems
- Y ☐ N ☐ Pain in jaw bone
- Y ☐ N ☐ Facial pain
- Y ☐ N ☐ Jaw locks
  Upper Lower
- Y ☐ N ☐ Limited opening of jaw
- Y ☐ N ☐ Teeth do not meet properly
- Y ☐ N ☐ Loss of teeth
- Y ☐ N ☐ Poorly fitting dental appliance
- Y ☐ N ☐ Pain in jaw joint
- Y ☐ N ☐ Gagging easily
- Y ☐ N ☐ Pain when swallowing
- Y ☐ N ☐ Head pain
- Y ☐ N ☐ Jaw clicks
- Y ☐ N ☐ Other
- Y ☐ N ☐ Are you currently in pain? ______________________________
- Y ☐ N ☐ Do you feel your oral condition is affecting your general health in any way? __________

____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

- Y ☐ N ☐ Antibiotics
- Y ☐ N ☐ Aspirin
- Y ☐ N ☐ Barbiturates
- Y ☐ N ☐ Codeine
- Y ☐ N ☐ Lidocaine
- Y ☐ N ☐ Latex
- Y ☐ N ☐ Metals
- Y ☐ N ☐ Plastic
- Y ☐ N ☐ Sedative
- Y ☐ N ☐ Sleeping pill
- Y ☐ N ☐ Local anesthetics
- Y ☐ N ☐ Other

____

LIST MEDICATIONS/SUBSTANCES YOU ARE CURRENTLY TAKING:

- Y ☐ N ☐ Antibiotics
- Y ☐ N ☐ Insulin
- Y ☐ N ☐ Anticoagulants
- Y ☐ N ☐ Muscle Relaxants
- Y ☐ N ☐ Barbiturates
- Y ☐ N ☐ Nerve pills
- Y ☐ N ☐ Blood thinners
- Y ☐ N ☐ Pain medication
- Y ☐ N ☐ Codeine
- Y ☐ N ☐ Sleeping pills
- Y ☐ N ☐ Other ______________________________
- Y ☐ N ☐ Cortisone
- Y ☐ N ☐ Sulfa Drugs
- Y ☐ N ☐ Ginko Biloba
- Y ☐ N ☐ Diet pills
- Y ☐ N ☐ Heart medication
- Y ☐ N ☐ Tranquilizers
- Y ☐ N ☐ Medications for osteoporosis
- Y ☐ N ☐ Bisphosphonates
- Y ☐ N ☐ Herbal supplements

CENTER FOR Complete Dentistry

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y ☐ N ☐ Abnormal bleeding after surgery/Injury
Y ☐ N ☐ Anemia
Y ☐ N ☐ Allergic Rhinitis
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Bloating
Y ☐ N ☐ Blood pressure ☐High ☐Low
Y ☐ N ☐ Bruising easily
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic Bronchitis
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Chronic mouth dryness
Y ☐ N ☐ Cold hands & feet
Y ☐ N ☐ Colitis
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Depression
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Excessive thirst
Y ☐ N ☐ Fainting spells
Y ☐ N ☐ Fluid retention
Y ☐ N ☐ Frequent cough
Y ☐ N ☐ Frequent illnesses
Y ☐ N ☐ Frequent stressful situations
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Gout
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Headaches
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Injury to
☐ Face ☐Neck ☐Mouth ☐Teeth
Y ☐ N ☐ Extra pillows to help breathing at night
Y ☐ N ☐ Tumors
Y ☐ N ☐ Urinary Disorders

Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Hypoglycemia
Y ☐ N ☐ Immune system disorder
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Kidney problems
Y ☐ N ☐ Liver disease
Y ☐ N ☐ Menstrual cramps
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle aches
Y ☐ N ☐ Muscle shaking (tremors)
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Muscula dystrophy
Y ☐ N ☐ Nasal Stuffiness in the morning
Y ☐ N ☐ Nervousness
Y ☐ N ☐ Neuralgia
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Ovarian cysts
Y ☐ N ☐ Parkinson's disease
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Prior orthodontic treatment
Y ☐ N ☐ Psychiatric treatment
Y ☐ N ☐ Rheumatoid arthritis
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Scarlet Fever
Y ☐ N ☐ Seizures
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Slow healing sores
Y ☐ N ☐ Sickle Cell Anemia
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Speech difficulties
Y ☐ N ☐ Stomach ulcers
Y ☐ N ☐ Stroke
Y ☐ N ☐ Swelling of ankles
Y ☐ N ☐ Tendency for frequent colds
Y ☐ N ☐ Tuberculosis

Y ☐ N ☐ Other Medical/Dental History ____

PLEASE LIST OTHER HEALTHCARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:

Practitioner	Specialty	Treatment & Approximate Date

Do you take aspirin regularly ☐YES ☐NO

Smoke tobacco ☐YES ☐NO

Has any close relative had a serious illness or condition? ______________________________

Emotional or nervous disturbances? ☐YES ☐NO

If yes, please explain: ____

____

____

____

Patient Signature:______________________________**Date:**____________________