Family Dental of South East Wisconsin, S.E. **General Dentistry**

Get acquainted and medical history questionnaire (CONFIDENTIAL)

Thank you for choosing our office to serve you. In order to serve you better, please fill in the following information completely. We have asked only questions that we feel necessary to protect you medically and to safeguard our staff. **Please complete both sides.**

Name____S.S.#____________________

Date of birth__________Phone(Hm)_______________Work_______________Cell___________

Address____

City _______________________________________State_____________Zip______________

Children: Name and Age____

Person responsible for Payment__________________________Their S.S.#___________________

Patient's Employer___________________________Occupation_____________________shift___

Employer Address____

Spouse's Name_______________________________________Their S.S.#___________________

Spouse's Employer___________________________Occupation____________________shift____

Spouse's Employer Address____

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

DENTAL HISTORY

Purpose of this visit and present problem____
Last dental visit______________________Last cleaning______________________________
When was your last full dental x-ray taken?____
Do you like your smile? Yes____No____ How often do you floss?________________________
How often do you Brush?_________________________Type of Brush used? Soft___Hard___
Do you use a power tooth brush? What brand? ____
Have you ever been instructed how to brush? Yes____ No____ How to floss? Yes____ No____
Are there any growths, sore spots, or unhealed areas in your mouth? Yes____No____
Have you had any difficult extractions in the past? Yes____No____
Have you ever had orthodontic treatment? Yes____No____
Do you smoke or chew tobacco? Yes____No____
Are any of your teeth currently sensitive to heat or cold? Yes____No____
Does food catch between your teeth? Yes____No____
Have you ever had any periodontal (gum) treatment? Yes____No____
Have you any objection to the use of local anesthetic (Novocain)? Yes____No____

Yes___No___Pain in or near you ear Yes___No___Dry sockets Yes__No___Bad Breath
Yes___No___Cold or canker sores Yes___No___Jaw clicking Yes__No__Bleeding Gums
Yes___No___Clench or grind teeth Yes___No___Pain when opening your jaw
Yes___No___Partials/dentures Yes___No___Do you snore

OVER>

MEDICAL HISTORY

Physician's name and address____
Date of last physical exam____________________Are you under medical care now? Yes__No__
Have you been in the hospital in the past 5 years? Yes__No__ For what? ____________________
Are you taking any drugs or medicine? Yes__No__ For What? __________________________
What medicines? ____
____
Are you taking Fosamax, Boniva or any other Bisphosphonate? Yes___No___
Are you allergic to any medication? Yes__No__ What are they___________________________
Are you allergic to metals? Yes___No___ What type?___________________________________
Are you on a special diet? Yes__No__ Are you pregnant? Yes__No__ If yes, due date_______
Are you in good health? Yes__No__ Do you use an inhaler? Yes__No__

Do you have any of the following? When___________________________________

Yes__No__Blood Disease/Anemia Yes__No__Diabetes Yes__No__Stroke

Yes__No__Rheumatism/Arthritis Yes__No__Radiation Treatment Yes__No__Cancer

Yes__No__Hepatitis/Liver disease Yes__No__Thyroid Condition Yes__No__AIDS

Yes__No__Epilepsy/Seizures Yes__No__High Blood Pressure Yes__No__Head or Jaw injury

Yes__No__Mental Retardation Yes__No__Pacemaker Yes__No__Kidney disease/Jaundice

Yes__No__Prolonged bleeding Yes__No__Blood transfusions Yes__No__Birth Control

Yes__No__Drug/Alcohol abuse Yes__No__Tumors/Growth Yes__No__Heart Trouble

Yes__No__Difficulty with sight Yes__No__Hard of hearing Yes__No__Other serious illness

Yes__No__Fainting/nervousness Yes__No__Stomach, intestinal disease Yes__No__Artificial Joints

Yes__No__Premedication (for what) ______________________

COMMENTS or CONCERNS: ____

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Signature: ____ **Date:** ____________________