Golden Dental Wellness Center

Date_____

Name _____ Home Phone (___)_____ _
Last First Middle

Address_____ Business Phone (_ __) _____

City_____ State_____ Zip Code_____

E-Mail Address_____ Cell Phone (__) ____ _____

Occupation_____ Social Security No._____

Date of Birth _ / _ / _ Sex M F Height_____ Weight_____Single_____ Married_____ Domestic Partner_____
mo. day yr.

Name of Spouse _____Closest Relative_____ Phone ( ) ____ _____

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

_____

Whom May We Thank For Referring You?_____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? . . . . . Yes No
2. Has there been any change in your general health within the past year?. . . . . Yes No
3. My last physical examination was on_____
4. Are you now under the care of a physician or naturopath? . . . . . Yes No
   If so, what is the condition being treated?_____
5. The name and address of my physician(s) and/or naturopath is:_____
   _____
   _____
   Phone #: _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?. . . Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? . . . . . Yes No
   If so, what medicine(s) are you taking? _____
   _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, including heart murmur, Mitral-Valve Prolapsed (MVP), or rheumatic disease . . . . . Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke). . . . . Yes No
      1. Do you have chest pain upon exertion? . . . . . Yes No
      2. Are you ever short of breath after mild exercise or when lying down?. . . . . Yes No
      3. Do your ankles swell? . . . . . Yes No
      4. Do you have inborn heart defects? . . . . . Yes No
      5. Do you have a cardiac pacemaker?. . . . . Yes No
   c. Have you had a hip replacement or any metal rods, pins, or implants? . . . . . Yes No
   d. Do you need to Pre-Medicate for your dental treatment? . . . . . Yes No
      1. If yes, reason why:_____
   e. Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? . . Yes No
   f. Seasonal Allergies . . . . . Yes No
   g. Sinus trouble. . . . . Yes No
   h. Asthma or hay fever. . . . . Yes No
   i. Fainting spells or seizures. . . . . Yes No
   j. Persistent diarrhea or recent weight loss. . . . . Yes No
   k. Diabetes . . . . . Yes No
   l. Hepatitis, jaundice or liver disease . . . . . Yes No
   m. Problems of the immune system. . . . . Yes No
   n. Sexually transmitted disease . . . . . Yes No
   o. AIDS or HIV infection. . . . . Yes No
   p. Thyroid problems . . . . . Yes No
   q. Respiratory problems, emphysema, bronchitis, etc.. . . . . Yes No
      1. Do you smoke any form of tobacco. . . . . Yes No
   r. Arthritis or painful swollen joints. . . . . Yes No
   s. Stomach ulcer or hyperacidity. . . . . Yes No
   t. Kidney trouble . . . . . Yes No
   u. Tuberculosis . . . . . Yes No
      1. Do you have a heavy, persistent cough of 2-3 weeks duration, particularly one that bring up sputum or bloodied sputum? . . . . . Yes No
      2. Do you wake up multiple times at night to change your clothes and bedding because they are unusually saturated with perspiration? . . . . . Yes No

v. Persistent swollen glands in neck. . . . . Yes No
w. Low blood pressure . . . . . Yes No
x. Epilepsy or other neurological disease . . . . . Yes No
y. Problems with mental health . . . . . Yes No
z. Cancer . . . . . Yes No

9. Have you had abnormal bleeding? . . . . . Yes No
   a. Have you ever required a blood transfusion?. . . . . Yes No
10. Do you have any blood disorder such as anemia?. . . . . Yes No
11. Have you ever had any treatment for a tumor or growth?. . . . . Yes No
12. Are you allergic or have you had a reaction 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
      1. Are you allergic to or unable to eat bananas, avocados, chestnuts, kiwis, potatoes, hazelnuts, or tomatoes? . . . . . Yes No
      2. Do you have history of surgery, especially, several repeated procedures in childhood? Yes No
      3. Do you have Spina Bifida? . . . . . Yes No
      4. Repeated urinary catherization? . . . . . Yes No
      5. Can you blow up balloons? . . . . . Yes No
   i. Other _____
13. Have you had any serious trouble associated with any previous dental treatment? . . . . . Yes No
   If so, explain _____
   _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . Yes No
   If so, explain _____
   _____
15. Are you wearing contact lenses? . . . . . Yes No
16. Are you wearing removable dental appliances?. . . . . Yes No
17. How many times a week do you floss? _____ a day do you brush? _____
18. What type of bristles do you use? _____soft _____medium _____hard _____don't know

Why have you come to the dentist today? _____
_____

Women:

19. Are you pregnant? . . . . . Yes No
20. Do you have any problems associated with you menstrual period?. . . . . Yes No
21. Are you nursing?. . . . . Yes No
22. Are you taking birth control pills? . . . . . Yes No

FAMILY HISTORY:

23. Please list any serious medical conditions your parents may have?_____

24. Do either of your parents have periodontal disease?_____

25. Does heart disease AND/OR diabetes run in your family?. . . . . Yes No
   a-If YES, what is their relation to you?_____

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/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/Parent or Guardian

Person Responsible for Account

_____ _____
Print Name Signature

For completion by the dentist:

Comments on patient interview concerning medical history:_____
_____

Significant findings from questions from questionnaire or oral interview:_____
_____

Dental management considerations:_____
_____

_____ _____
(Date) Signature of Dentist