Dental Associates of Maitland, P.A. **Health Questionnaire**

Bernard A. Kahn D.D.S.

The answers to the following are for our records only. Thanks!

Name: _____ Sex: ____ DoB: _____Marital Status: _____

Address: _____ City: _____Zip:_____

Phone: (H) _____ (W) _____ (Cell) _____

(Fax)_____ Email:_____

Spouse (or Guardian): _____ Referred by: _____

Who will pay for this account: _____ Relation: _____

Please circle yes or no and fill in blanks

Are you in good health? ----------yes no

Has there been a change to your health in the last year? ----------yes no

My last medical/physical examination was on: _____ By: _____

Are you currently under a physician's care? ----------yes no
Name of physician: _____

Have you had any serious illness, hospitalization or operation? ----------yes no

Do you have or have you had any of the following:

Rheumatic fever, rheumatic heart disease ----------yes no

Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, high blood pressure, valvular disease) ----------yes no

Allergy, asthma, hay fever, hives, or skin rash ----------yes no

Fainting Spell or seizures----------yes no

Diabetes ----------yes no

Hepatitis, jaundice, or liver disease ----------yes no

Arthritis----------yes no

Inflammatory rheumatism ----------yes no

Stomach or intestinal ulcers ----------yes no

Kidney disease ----------yes no

Tuberculosis, chronic cough ----------yes no

Sexually transmitted disease ----------yes no

Sinus trouble, pain, discharge ----------yes no

Tobacco use, if so, form and frequency: _____yes no

HIV, AIDS, night sweats, unexplained weight loss----------yes no

Substance dependency ----------yes no

Cancer ----------yes no

Psychiatric disease/depression----------yes no

Other: _____

Have you had surgery or X-ray treatment for a tumor?----------yes no

Do you have any blood disorder such as anemia?----------yes no

Have you had abnormal bleeding associated with surgery?----------yes no

Are you taking a medicine or supplement, if so what?_____yes no

Are you allergic or have you reacted adversely to:

Local Anesthetics?----------yes no **Penicillin?----------yes no**

Sulfa Drugs ?----------yes no **Barbiturates?----------yes no**

Aspirin?----------yes no **Iodine ?----------yes no**

Codeine?----------yes no **Other?----------yes no**

_____ _____

Signature **Date**

Dental Associates of Maitland, P.A. Dental Questionnaire

Bernard A. Kahn D.D.S.

The answers to the following are for our records only! Thanks!

Name: _____

Have you had trouble with previous dental therapy?----------yes no

Do you notice bleeding from your gums?----------yes no

Do you have bad breath?----------yes no

Are your teeth sensitive, if so to what? _____ yes no

Are you subject to headache, neck pain, or shoulder pain?----------yes no

Do you hear popping or clicking noises as you chew or move your jaws?-------yes no

Have you ever had teeth removed? ----------yes no

Have you worn partials, dentures or bridges?----------yes no

Do you floss?----------yes no

Do you understand your nutritional needs?----------yes no

Do you notice yourself clenching or grinding your teeth?----------yes no

Do you have pain in opening your jaws widely or side to side?----------yes no

Do you chew on one side?----------yes no

Are your teeth white enough?----------yes no

Are you happy with the angulation of your teeth?----------yes no

When was your last dental cleaning ?_____

If you could change something about your smile or teeth you would:

_____

_____

_____

_____

_____ _____

Signature **Date**