IMPLANT CONSULTATION

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:____

ADDRES:S____

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

Yes☐ No ☐ Diet limited to semisolid food or soft foods
Yes☐ No☐ Mouth sores
Yes☐ No☐ Diet limited to liquid foods
Yes☐ No☐ Numbness in lower lip
Yes☐ No☐ Difficulty chewing
Yes☐ No☐ Numbness in jawbone
Yes☐ No☐ Difficulty speaking
Yes☐ No ☐ Tingling in jawbone
Yes☐ No☐ Difficulty swallowing
Yes☐ No ☐ Nutritional disorders
Yes☐ No☐ Digestive problems
Yes☐ No ☐ Pain in jaw bone
Yes☐ No☐ Facial pain

Yes☐ No☐ Jaw locks
☐ upper ☐ lower
Yes☐ No☐ Limited opening of jaw
Yes☐ No ☐ Teeth do not meet properly
Yes☐ No☐ Loss of teeth
Yes ☐ No☐ Poorly fitting dental appliance
Yes☐ No ☐ Pain in jaw joint
Yes☐ No☐ Gagging easily
Yes ☐ No☐ Pain when swallowing
Yes☐ No☐ Head pain
Yes ☐ No☐ Pain when chewing
Yes☐ No☐ Jaw clicks
Yes☐ NO☐ Other

Yes☐ No☐ Are you currently in pain? ____
Yes☐ No☐ Do you feel your oral condition is affecting your general health in any way? ______________
____

LIST ANY MEDICATIONS/SUBSTANCES WICH 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 ☐ Local anesthetics
Y☐ N☐ Sulfa drugs
Y☐ N ☐ Other

Y☐ N☐ Metals
Y☐ N☐ Plastic
Y☐ N☐ Sedative
Y☐ N☐ Sleeping pill

____

LIST ANY MEDICATIONS/SUPPLEMENTS CURRENTLY BEING TAKEN:

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

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

Practitioner	Specialty	Treatment & Approximate date

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y☐ N ☐ Abnormal bleeding after surgery or 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 ☐ Needing 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____

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**_____________________________