

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: _____

ADDRESS: _____

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

- | | |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Diet limited to semisolid food or soft foods | Yes <input type="checkbox"/> No <input type="checkbox"/> Jaw locks |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Mouth sores | <input type="checkbox"/> upper <input type="checkbox"/> lower |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Diet limited to liquid foods | Yes <input type="checkbox"/> No <input type="checkbox"/> Limited opening of jaw |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Numbness in lower lip | Yes <input type="checkbox"/> No <input type="checkbox"/> Teeth do not meet properly |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Difficulty chewing | Yes <input type="checkbox"/> No <input type="checkbox"/> Loss of teeth |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Numbness in jawbone | Yes <input type="checkbox"/> No <input type="checkbox"/> Poorly fitting dental appliance |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Difficulty speaking | Yes <input type="checkbox"/> No <input type="checkbox"/> Pain in jaw joint |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Tingling in jawbone | Yes <input type="checkbox"/> No <input type="checkbox"/> Gagging easily |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Difficulty swallowing | Yes <input type="checkbox"/> No <input type="checkbox"/> Pain when swallowing |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Nutritional disorders | Yes <input type="checkbox"/> No <input type="checkbox"/> Head pain |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Digestive problems | Yes <input type="checkbox"/> No <input type="checkbox"/> Pain when chewing |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Pain in jaw bone | Yes <input type="checkbox"/> No <input type="checkbox"/> Jaw clicks |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Facial pain | Yes <input type="checkbox"/> NO <input type="checkbox"/> Other |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Are you currently in pain? _____ | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Metals |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Sedative |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pill |
| Y <input type="checkbox"/> N <input type="checkbox"/> Lidocaine | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Latex | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other | |
-

LIST ANY MEDICATIONS/SUPPLEMENTS CURRENTLY BEING TAKEN:

- | | |
|--|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone |
| Y <input type="checkbox"/> N <input type="checkbox"/> Insulin | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Ginko Biloba |
| Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication |
| Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills | Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Medications for Osteoporosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication | Y <input type="checkbox"/> N <input type="checkbox"/> Bisphosphonates |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Herbal Supplements |
| Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other _____ | |

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 <input type="checkbox"/> N <input type="checkbox"/> Abnormal bleeding after surgery or injury | Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anemia | Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker |
| Y <input type="checkbox"/> N <input type="checkbox"/> Allergic Rhinitis | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement |
| Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis | Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Asthma | Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders | Y <input type="checkbox"/> N <input type="checkbox"/> Hypoglycemia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily | Y <input type="checkbox"/> N <input type="checkbox"/> Immune system disorder |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bloating | Y <input type="checkbox"/> N <input type="checkbox"/> Insomnia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low | Y <input type="checkbox"/> N <input type="checkbox"/> Intestinal disorders |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bruising easily | Y <input type="checkbox"/> N <input type="checkbox"/> Jaw joint surgery |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cancer | Y <input type="checkbox"/> N <input type="checkbox"/> Kidney problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> Liver disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic Bronchitis | Y <input type="checkbox"/> N <input type="checkbox"/> Menstrual cramps |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue | Y <input type="checkbox"/> N <input type="checkbox"/> Multiple sclerosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic mouth dryness | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle aches |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cold hands & feet | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle shaking (tremors) |
| Y <input type="checkbox"/> N <input type="checkbox"/> Colitis | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle spasms or cramps |
| Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy | Y <input type="checkbox"/> N <input type="checkbox"/> Muscula dystrophy |
| Y <input type="checkbox"/> N <input type="checkbox"/> Depression | Y <input type="checkbox"/> N <input type="checkbox"/> Nasal Stuffiness in the morning |
| Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes | Y <input type="checkbox"/> N <input type="checkbox"/> Nervousness |
| Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness | Y <input type="checkbox"/> N <input type="checkbox"/> Neuralgia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema | Y <input type="checkbox"/> N <input type="checkbox"/> Osteoporosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy | Y <input type="checkbox"/> N <input type="checkbox"/> Ovarian cysts |
| Y <input type="checkbox"/> N <input type="checkbox"/> Excessive thirst | Y <input type="checkbox"/> N <input type="checkbox"/> Parkinson's disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> Fainting spells | Y <input type="checkbox"/> N <input type="checkbox"/> Poor circulation |
| Y <input type="checkbox"/> N <input type="checkbox"/> Fluid retention | Y <input type="checkbox"/> N <input type="checkbox"/> Prior orthodontic treatment |
| Y <input type="checkbox"/> N <input type="checkbox"/> Frequent cough | Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric treatment |
| Y <input type="checkbox"/> N <input type="checkbox"/> Frequent illnesses | Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatoid arthritis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Frequent stressful situations | Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma | Y <input type="checkbox"/> N <input type="checkbox"/> Scarlet Fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> Gout | Y <input type="checkbox"/> N <input type="checkbox"/> Seizures |
| Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever | Y <input type="checkbox"/> N <input type="checkbox"/> Shortness of breath |
| Y <input type="checkbox"/> N <input type="checkbox"/> Headaches | Y <input type="checkbox"/> N <input type="checkbox"/> Slow healing sores |
| Y <input type="checkbox"/> N <input type="checkbox"/> Hearing impairment | Y <input type="checkbox"/> N <input type="checkbox"/> Sickle Cell Anemia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur | Y <input type="checkbox"/> N <input type="checkbox"/> Sinus problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> Injury to | Y <input type="checkbox"/> N <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | Y <input type="checkbox"/> N <input type="checkbox"/> Stomach ulcers |
| Y <input type="checkbox"/> N <input type="checkbox"/> Needing extra pillows to help breathing at night | Y <input type="checkbox"/> N <input type="checkbox"/> Stroke |
| Y <input type="checkbox"/> N <input type="checkbox"/> Tumors | Y <input type="checkbox"/> N <input type="checkbox"/> Swelling of ankles |
| Y <input type="checkbox"/> N <input type="checkbox"/> Urinary disorders | Y <input type="checkbox"/> N <input type="checkbox"/> Tendency for Frequent Colds |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other Medical/Dental History _____ | Y <input type="checkbox"/> N <input type="checkbox"/> Tuberculosis |

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** _____