CAROL SCHAFFER, D.M.D. LINVILLE, NC 28646 (828) 737-7722
Patient Medical History Questionnaire

Name: Last_____ First_____MI_____ Preferred_____

Sex: M / F **Marital Status**: Married Single Child Other **Date of Birth**:_____/_____/_____

Social Security Number:_____/_____/_____ Dr**ivers License Number**:_____**State**_____
Employer_____**Occupation**_____

Local

Mailing Address_____City_____State_____Zip_____

Physical Address_____City_____State_____Zip_____

Home Phone_____ **Work**_____**Cellular**_____

Seasonal/Other

Mailing Address_____City_____State_____Zip_____

Physical Address_____City_____State_____Zip_____

Home Phone_____Email Address:_____

Person to Notify in case of Emergency:_____Phone_____

Primary Physician_____ Phone Number _____

Who may we thank for referring you?_____

For the following questions, please circle YES or NO, whichever applies, and comment where you wish. Your answers are for our records only and will be considered confidential.

YES / NO 1. Are you in good health? _____

YES / NO 2. Has there been any changes in your general health in the past year?_____

_____

YES / NO 3. Are you under the care of a physician? If so, what is the condition being treated?_____

_____

YES / NO 4. Have you had any serious illness, or been hospitalized in the past five years? If so, what was the problem?___

_____

YES / NO 5. Are you taking any medications now? If yes, please list:_____
_____

YES / NO 6. Have you ever had joint replacement or joint surgery? Date:_____

7. What was the date of your last dental visit?_____

YES / NO 8. Have you had a toothache recently, or do you have sensitive teeth?_____

YES / NO 9. Do you have any difficulty in chewing?_____

YES / NO 10. Do you have bleeding gums?_____

YES / NO 11. Are you aware of any loose teeth?_____

YES / NO 12. Are you aware of clenching or grinding your teeth during tension or sleep?_____

YES / NO 13. Is it difficult for you to open you mouth as widely as you would like?_____

YES / NO 14. Are your jaw muscles ever sore upon awakening?_____

YES / NO 15. Have you ever had your bite adjusted?

YES / NO 16. Do you have frequent headaches? If so, do they require medication? Please list_____

YES / NO 17. Have you ever suffered an injury to your face or jaw?_____

YES / NO 18. Have you ever had surgery or x-ray treatment for a tumor, growth or any condition in your mouth or on your lips?_____

YES / NO 19. Do you have any of the following oral habits? If so, please circle:

SMOKING ALCOHOL USE CHEWING TOBACCO CHEWING GUM NAIL BITING

20. **Do you have, or have you ever had any of the following conditions?**

YES / NO Damaged heart valve(s) or artificial heart valve(s) **(please circle all that apply)**

Heart Murmur **Mitral Valve Prolapse** **Rheumatic Heart Disease**

YES / NO Cardiovascular Disease If yes, **(please circle all that apply)**

Heart Attack Angina Arteriosclerosis Stroke Coronary Insufficiency Coronary Occlusion

YES / NO	**Asthma**	YES / NO	**Immune System Problems**
YES / NO	**Cancer** (type)_____	YES / NO	**Kidney Problems**
YES / NO	**Diabetes**	YES / NO	**Mouth Ulcers**
YES / NO	**Epilepsy**	YES / NO	**Seizures**
YES / NO	**Fainting Spells**	YES / NO	**Sinus Trouble**
YES / NO	**Hay Fever**	YES / NO	**Thyroid Problems**
YES / NO	**Hepatitis**	YES / NO	**Tuberculosis**
YES / NO	**High Blood Pressure**		

YES / NO Allergies: (please list)_____

YES / NO Medication Allergies (please list)_____

YES / NO 21.Have you or any member of your immediate family ever had any sexually transmitted disease, such as:

(please circle) AIDS, HIV, Syphilis, Gonorrhea, Clamdia, Genital Herpes

YES / NO 22. Are you wearing contact lenses?

YES / NO 23. Are there any other significant medical problems?_____

YES / NO 24. Are you worried about receiving dental treatment? (why?)_____

YES / NO 25. Have you been pleased with your past dental care?

YES / NO 26. Are you interested in whitening your teeth?

YES / NO 27. Is there anything else that you would like for the doctor to know before beginning treatment?_____

_____

YES / NO ***28. HAVE YOU EVER BEEN TOLD TO PRE-MEDICATED WITH ANTIBIOTICS ON A REGULAR BASIS, BEFORE A DENTAL PROCEDURE? IF SO, WHY?_____

SIGNATURE:_____**DATE: _____/_____/_____**

FEMALES ONLY:

29. YES / NO Are you pregnant or nursing?

30. YES / NO Are you taking birth control pills?

31. YES / NO Are you taking any oral medication for bone loss? (such as Fosamax or Boniva) If so, Please list_____