emma kim.dmd

Personal Questionnaire Form

personal information

Name of Patient_____
Address_____
_____
_____
Home Phone_____
Business Phone_____
Cell_____
Person to call in an emergency_____
Their Phone #_____
Person responsible for the account_____
Their Relationship to the Patient_____
If you are completing this form for another person, what is your relationship to that person? _____

Social Security #_____
E-Mail Address_____
May we contact you by e-mail? Y / N
Date of Birth_____
Sex M / F
Height_____
Weight_____

Occupation_____
Marital Status S / M / D / W
Name of Spouse_____
If this is your first visit, whom may we thank for referring you?
_____

dental insurance

Insurance Carrier_____
Phone_____
Group #_____
Relationship to Subscriber Self / Spouse / Child

Subscriber Name_____
Subscriber Soc. Sec. #_____
Group Name (Employer)_____

medical history

Please answer the following questions. Your answers are for our records only and will be considered confidential.

Do you feel healthy? Yes / No
Are you in the care of a physician? Yes / No
Date of last exam_____
Name & Address of physician_____
_____
_____

Any past or present serious illnesses, operations, or hospitalizations?_____
_____
List any change in your health within the past year_____
_____
_____

Circle "yes" if you have or have ever had any of the following illnesses:

1. Cardiovascular disease (heart)
   - a) damaged heart valve..... Y / N
   - b) artificial heart valve..... Y / N
   - c) heart murmur..... Y / N
   - d) heart attack..... Y / N
   - e) high blood pressure..... Y / N
   - f) low blood pressure..... Y / N
   - g) pacemaker or defibrillator..... Y / N
   - h) coronary occlusion..... Y / N
   - i) congenital heart lesions..... Y / N
   - j) shortness of breath after mild exercise..... Y / N
   - k) chest pain upon exertion..... Y / N
   - l) shortness of breath when lying down..... Y / N
   - m) need extra pillows when sleeping..... Y / N
   - n) ankles swell..... Y / N
   - o) rheumatic heart disease..... Y / N
   - p) coronary insufficiency or arteriosclerosis..... Y / N
   - q) congestive heart failure..... Y / N
   - r) on blood thinners..... Y / N
2. Allergic reactions
   - a) allergies (drug allergies listed later)..... Y / N
   - b) sinus trouble..... Y / N
   - c) asthma or hay fever (circle which one)..... Y / N
3. Fainting spells, seizures, epilepsy (circle which one)..... Y / N
4. Muscular skeletal problems..... Y / N
   - a) arthiritis..... Y / N
   - b) prosthetic joint replacement..... Y / N
   - c) Inflammatory rheumatism (painful swollen joints)..... Y / N
   - d) osteoporosis..... Y / N
5. Stomach, duodenal ulcers or hiatus hernia..... Y / N
6. Thyroid dysfunction..... Y / N

(over)

7. Hepatitis, jaundice (yellow skin), cirrhosis, or other liver disease ..... Y / N
8. Kidney trouble ..... Y / N
9. Tuberculosis or other upper respiratory problems ..... Y / N
10. Glaucoma ..... Y / N
11. Diabetes ..... Y / N
12. Venereal disease (sexually transmitted disease) ..... Y / N
13. Psychiatric or emotional problems ..... Y / N
14. Cancer ..... Y / N
15. Immunosuppressive disorders (HIV/AIDS) ..... Y / N
16. Bleeding disorders
    a) Abnormal bleeding associated with previous extractions, surgery, or trauma ..... Y / N
    b) Do you bruise easily? ..... Y / N
    c) Blood transfusion (if so, when and why?) ..... Y / N
    d) Any blood disorder such as anemia? ..... Y / N
17. Any surgery, x-ray or drug treatment for a tumor, growth or other condition of your head or neck? ..... Y / N
    if so, explain _____
18. Any disease, condition or problem not listed above that you think we should know about? ..... Y / N
    if so, explain _____
19. Are you or any family members in a relationship with anyone hurting or threatening you or them? ..... Y / N
20. Are you pregnant or nursing? ..... Y / N
21. Are you now or have you ever taken Phen Fen or similar diet drugs? ..... Y / N

List all medications you are taking, including vitamins: _____

_____

Are you allergic or have you reacted adversely to:

a) Local anesthetics (novocain) ..... Y / N
b) Nitrous oxide ..... Y / N
c) Aspirin ..... Y / N
d) Codeine or other narcotics ..... Y / N
e) Penicillin, sulfa or other antibiotics ..... Y / N
f) Barbituates, sedatives, or sleeping pills ..... Y / N
g) Latex ..... Y / N
h) Other ..... Y / N
please list _____

Have you had any serious trouble associated with any previous dental treatment? ..... Y / N
if so, explain _____

dental history

Chief dental complaint (the reason for you visit): _____

Date of your last dental treatment _____
Date of your last X-Rays _____
Frequency of dental visits _____
Frequency of dental cleanings _____
How often do you brush your teeth per day? _____
How often do you floss? _____

Do you use any of the following:

a) Fluoride rinse ..... Y / N
b) Mouth rinse or wash ..... Y / N
c) Chewing gum ..... Y / N
d) Night guard ..... Y / N
e) Tooth bleaching ..... Y / N
f) Any dental appliance ..... Y / N

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

a) Bleeding, sore gums ..... Y / N
b) Burning tongue or lips ..... Y / N
c) Blisters or sores on mouth or lips ..... Y / N
d) Biting cheeks or lips ..... Y / N
e) Dry mouth ..... Y / N
f) Unpleasant taste or bad breath ..... Y / N
g) Food impaction, catching ..... Y / N
h) Tooth sensitivity to hot, cold, sweets, bite ..... Y / N
i) Gum treatment ..... Y / N
j) Gum or bone surgery ..... Y / N
k) Shifting teeth, change in bite ..... Y / N
l) Swellings, lumps in the mouth ..... Y / N

Relating to craniomandibular disorders (TMJ), do you have or have you ever had:

a) Difficulty or pain opening mouth ..... Y / N
b) Jaw getting stuck, locked, or "going out" ..... Y / N
c) Difficulty or pain chewing or talking ..... Y / N
d) Noises in the jaw joints ..... Y / N
e) Soreness of jaw muscles ..... Y / N
f) Pain in or near ears, temples, or cheeks ..... Y / N
g) Clenching or grinding teeth ..... Y / N
h) Frequent headaches ..... Y / N
i) Recent injury to head, neck, or jaw ..... Y / N
j) Unusual or uncomfortable bite ..... Y / N
k) An adjustment to your bite ..... Y / N
l) Treatment for jaw/joint problem ..... Y / N

Do you drink alcohol? If so, state how much per day or week ..... Y / N

Do you use tobacco? ..... Y / N

If so: What type? _____ How many per day? _____ Since what age? _____

_____ _____ _____ _____
Parent or Guardian Signature | Date | Dentist Signature | Date