Creekwood Dental Arts

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Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Title: __________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **Prev. Visit:** ____________ **Email Address:** ______________________

Phone: ____________ ____________ ____________ ______
Home Mobile Work Ext

Best time to call: ______________________

Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

In an emergency, who should be notified? Please enter name, phone number, and relationship below:

Emergency Contact: *

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What is your most important concern today? *

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Are you currently taking any medications (including prescription, OTC medications, vitamins, and supplements)? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Medications:

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Do you take pre medication for dental procedures? * ◯ Yes ◯ No

Do you have any allergies and/or allergies to medications? If yes, please list all allergies below: * ◯ Yes ◯ No

Allergies:

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Have you ever had surgery? If yes, please list all surgeries. * ◯ Yes ◯ No

Surgeries:

Have you ever been hospitalized? If yes, please list all hospitalizations. * ◯ Yes ◯ No

Hospitalizations:

Name of physician, approximate date of last physical exam, and physician's phone number: *

Name of Patient, Parent, or Guardian completing this form *

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Caries/Tooth Decay (select all that apply): *

- [ ] Consider yourself cavity prone
- [ ] Consume sugary foods on a regular basis
- [ ] Consume any citrus-flavored beverages
- [ ] Dry mouth
- [ ] Heartburn/reflux
- [ ] Have holes, pitting, or notches in your teeth
- [ ] None

If any responses need further clarification, please describe below:

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Periodontal Disease (select all that apply): *

- [ ] Been told you have gingivitis or gum disease in the past
- [ ] Have bleeding when you clean between your teeth
- [ ] Have gum recession or exposed root surfaces
- [ ] Have any loose teeth, drifting teeth, or areas that collect food when you eat
- [ ] Notice bad breath or burning sensation
- [ ] None

If any responses need further clarification, please describe below:

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Oral Cancer (select all that apply): *

- [ ] Smoke tobacco
- [ ] Chew tobacco
- [ ] Have any persistent sore spots in your mouth or lumps/bumps in your head or neck
- [ ] Feel as if you have a lump in your throat
- [ ] Think you are at risk for HPV infection
- [ ] None

If any responses need further clarification, please describe below:

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Function/Bite/TMJ Dysfunction (select all that apply): *

- [ ] Missing teeth other than your wisdom teeth
- [ ] Experience discomfort when chewing
- [ ] Jaw joints click, pop, or make grinding sounds
- [ ] Experience frequent headaches or jaw/facial pain
- [ ] Joints get stuck or locked
- [ ] Treated for a jaw joint problem in the past (If yes, explain below.)
- [ ] Wear removable dentures or partial dentures (If yes, are they comfortable/well-fitting?)
- [ ] Clench/grind during sleep or in daytime
- [ ] None

If any responses need further clarification, please describe below:

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Cardiovascular Health (select all that apply): *

- [ ] High blood pressure/Hypertension
- [ ] Heart disease
- [ ] Heart valve replacement
- [ ] Heart attack
- [ ] Stroke
- [ ] Heart surgery
- [ ] Stent
- [ ] Pacemaker
- [ ] Fainting/dizziness
- [ ] Experience shortness of breath of chest pain/angina
- [ ] High cholesterol
- [ ] Irregular heart beat/arrhythmia/heart murmur
- [ ] None

If any responses need further clarification, please describe below:

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Respiratory Disease (select all that apply): *

- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Allergies (seasonal)
- [ ] Sinus problems
- [ ] None

If any responses need further clarification, please describe below:

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Brain Health (select all that apply): *

- [ ] Dementia
- [ ] Alzheimer's Disease
- [ ] Parkinson's Disease
- [ ] Depression
- [ ] Anxiety Disorder
- [ ] Past brain/head trauma
- [ ] Seizure/Epilepsy
- [ ] ADD/ADHD
- [ ] Mental Disorders
- [ ] Psychiatric Treatment
- [ ] Lost interest in activities that used to make you happy
- [ ] Experience "brain fog" where your awareness of surroundings seems dulled
- [ ] Have difficulty remembering names or words you want to use
- [ ] Frequently forget where you put your keys or phone or how to get from place to place
- [ ] None

If any responses need further clarification, please describe below:

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Diabetes (select all that apply): *

- [ ] Diabetes
- [ ] Gums bleed when you brush or floss
- [ ] None

If any responses need further clarification, please describe below:

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Blood Disorders (select all that apply):

☐ AIDS/HIV ☐ Anemia ☐ Sickle Cell Disease ☐ Bruise easily ☐ Excessive bleeding ☐ None

If any responses need further clarification, please describe below:

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Cancer (select all that apply): *

☐ Undergoing cancer treatment ☐ History of cancer ☐ History of radiation
☐ History of chemotherapy ☐ Have suspicion or fear of cancer in your body ☐ None

If any responses need further clarification, please describe below:

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Dependency/Addiction *

☐ Currently in recovery or being treated for addiction
☐ Smoke tobacco
☐ Chew tobacco
☐ Want to quit using tobacco
☐ Drug/alcohol addiction
☐ Depend on any prescription or non-prescription drugs to sleep, wake, or relieve pain
☐ Consume caffeine in excess of three 8-oz servings a day
☐ Feel you are addicted to any sugar
☐ None

If any responses need further clarification, please describe below:

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Bone Health (select all that apply): *

☐ Osteopenia/Osteoporosis ☐ Abnormal bone density test ☐ Vitamin D deficiency ☐ None

Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing Bisphosphonates? * ◯ Yes ◯ No

If any responses need further clarification, please describe below:

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Joints (select all that apply): *

☐ Joint inflammation ☐ Joint pain ☐ Arthritis ☐ Gout ☐ Artifical joint ☐ None

If any responses need further clarification, please describe below:

Women's Health (select all that apply): *

- [ ] Pregnant/planning pregnancy/nursing
- [ ] Taking birth control
- [ ] None

If any responses need further clarification, please describe below:

Organ Dysfunction (select all that apply): *

- [ ] Thyroid disease
- [ ] Jaundice
- [ ] Hepatitis
- [ ] Liver disease
- [ ] Kidney disease
- [ ] Oral or injection steroids
- [ ] Stomach problems
- [ ] Glaucoma
- [ ] Rheumatic Fever
- [ ] STD
- [ ] None

If any responses need further clarification, please describe below:

Family History of Medical Conditions (please list condition and relationship to family member):

Sleep (select all that apply): *

- [ ] You or your bed partner snore
- [ ] Experience interruptions in breathing during sleep
- [ ] Have difficulty sleeping
- [ ] Feel tired or fatigued during the day
- [ ] Completed a sleep study
- [ ] Use a CPAP or oral sleep appliance
- [ ] Remember dreaming
- [ ] None

If any responses need further clarification, please describe below:

Allergies, Food Sensitivities, and Other Chronic Inflammatory Conditions (select all that apply): *

- [ ] Irritable Bowl Syndrome (IBS)
- [ ] Fibromyalgia
- [ ] Chronic fatigue syndrome
- [ ] Insulin resistance
- [ ] Periodontal/gum disease
- [ ] Other chronic inflammatory conditions
- [ ] Food sensitivities to dairy, wheat, or soy
- [ ] Difficulty losing weight despite considerable effort
- [ ] Regularly eat foods that make you feel sluggish, sick, or guilty
- [ ] Have red, patchy, or itchy skin or itchy ears
- [ ] Follow a special diet
- [ ] Aspire to make changes to your diet
- [ ] Desire a change in weight
- [ ] None

If any responses need further clarification, please describe below:

What sugary food or drinks do you consume regularly?
List any beverages you consume on a regular basis.

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Do you exercise regularly? How many times per week? What do you currently do for exercise? Do you have exercise goals you hope to achieve?

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Any additional health issues/concerns not already addressed:

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Response Date: ____/____/________