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___(II: 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 ❑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 hone
Yes ❑No ❑ Facial pain
Yes ❑No ❑Jaw blocks
❑ 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 ❑El 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 THAT 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 ❑ Metals
Y ❑N ❑ Plastic
Y ❑N ❑ Sedative
Y ❑N ❑ Sleeping pill
Y ❑N ❑ Other

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 9MONTHS

Practitioner Specialty Treatment & Approximate date

_____

_____

MEDICAL HISTORY(Please indicate dates on questions checked YES)	
Y ❑N ❑Abnormal bleeding after surgery or injury	Y ❑N ❑ Heart disorder
Y ❑N ❑ Anemia	Y ❑N ❑ Heart pacemaker
Y ❑N ❑ Allergic rhinitis	Y ❑N ❑ Heart valve replacement
Y ❑N ❑ Arteriosclerosis	Y ❑N ❑ Hemophilia
Y ❑N ❑ Asthma	Y ❑N ❑ Hepatitis
Y ❑N ❑ Autoimm.une disorders	Y ❑N ❑ Hypoglycemia
Y ❑N ❑ Bleeding easily	Y ❑N ❑ Immune system disorder
Y ❑N ❑ Bloating	Y ❑N ❑ Insomnia
Y ❑N ❑ Blood pressure ❑ High ❑ Low	Y ❑N ❑ Intestinal disorders
Y ❑N ❑cruising easily	Y ❑N Jaw joint surgery
Y ❑N ❑ Cancer	Y ❑N ❑ Kidney problems
Y ❑N ❑ Chemotherapy	Y ❑N ❑ Liver disease
Y ❑N ❑ Chronic bronchitis	Y ❑N ❑ Menstrual cramps
Y ❑N ❑ Chronic fatigue	Y ❑N ❑ Multiple sclerosis
Y EIN ❑ Chronic mouth dryness	Y ❑N ❑ Muscle aches
Y ❑N ❑ Cold hands & feet	Y ❑N ❑ Muscle shaking (tremors)
Y ❑N ❑ Colitis	Y ❑N ❑ Muscle spasms or cramps
Y ❑N ❑ Current pregnancy	Y ❑N ❑ Muscula dystrophy
Y ❑ N ❑ Depression	Y ❑ N ❑Nasal stuffiness in the morning
Y ❑N ❑ Diabetes	Y ❑N ❑ Nervousness
Y ❑N -❑ Dizziness	Y ❑N ❑ Neuralgia
Y ❑ N ❑ Emphysema	Y ❑ N ❑ Osteoporosis
Y ❑N❑ Epilepsy	YEN ❑ Ovarian cysts
Y ❑N ❑ Excessive thirst	Y ❑N ❑ Parkinson's disease
Y ❑N ❑ Fainting spells	Y ❑N ❑ Poor circulation
Y ❑N ❑ Fluid retention	Y ❑N ❑ Prior orthodontic treatment
Y ❑N ❑ Frequent cough	Y ❑ N ❑ Psychiatric treatment
Y❑'N❑ Frequent illnesses	Y ❑N ❑ Rheumatoid arthritis
Y ❑N ❑ Frequent stressful situations	Y ❑ N ❑ Rheumatic fever
Y ❑N ❑ Glaucoma	Y ❑N ❑ Scarlet fever
Y ❑N ❑ Gout	YEN ❑ Seizures
Y ❑N ❑ Hay fever	Y ❑N ❑ Shortness of breath
Y ❑N ❑ Headaches	Y ❑N ❑ Slow healing sores
Y ❑N ❑ Hearing impairment	Y ❑N ❑ Sickle cell anemia
Y ❑N ❑ Heart murmur	Y ❑N ❑ Sinus problems
Y ❑N ❑ Injury to	Y ❑N ❑ Speech difficulties
❑Face ❑Neck ❑Mouth❑Teeth	Y ❑N ❑ Stomach ulcers
Y ❑N. ❑ Needing extra pillows to help breathing at night	Y ❑N ❑ Stroke
Y ❑N ❑ Tumors	Y ❑N ❑ Swelling of ankles
Y ❑ N ❑ Urinary disorders	Y ❑N ❑ Tendency for frequent colds
Y ❑N ❑ Other medical/dental history	Y ❑N ❑ Tuberculosis

Smoke tobacco? ❑Yes ❑No

Do you take aspirin regularly? ❑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_____