Elaine K. Sours, D.D.S., P.C.

Please fill out completely

Today's Date _____

Patient Name _____ S. S. No. _____ Birthdate _____

Residence _____ City, State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Height _____ Weight _____ Single _____ Married _____ Occupation _____

Employer Name_____ Work Phone _____ Dental Insurance _____

Policyholder Name _____ ID Number _____ Insurance Phone No._____

Spouse/Guardian Name _____ S.S. No. _____ Birthdate_____

Occupation _____ Employer Name _____ Work Phone _____

Referred By (We like to say "Thank You") _____

GENERAL HEALTH QUESTIONNAIRE **YES** **NO**

My last physical examination was on _____

Are you under the care of a physician? ☐ ☐

a. If yes, what is the condition being treated? _____

_____

Name and phone number of physician _____

_____

Have you had any serious illness or operation? ☐ ☐

a. If yes, what was the illness or operation? _____

_____

Are you taking any medications? ☐ ☐

a. If yes, what? _____

_____

Are you taking the following:

a. Aspirin	☐	☐
b. Anticoagulants/Blood Thinner	☐	☐
c. Antidepressants/Tranquilizers	☐	☐
d. Blood Pressure Medicine	☐	☐
e. Cortisone (steroids)	☐	☐
f. Heart Medications	☐	☐
g. Insulin	☐	☐
h. Nitroglycerin	☐	☐

Do you have or have you had any of the following diseases or problems:

a. AIDS, ARC, HIV+	☐	☐
b. Arthritis	☐	☐
c. Artificial Heart Valves	☐	☐
d. Asthma	☐	☐
e. Cancer/Chemotherapy	☐	☐
f. Diabetes	☐	☐
g. Difficulty Breathing	☐	☐
h. Epilepsy/Seizures	☐	☐
i. Excessive Bleeding or Clotting Problems	☐	☐
j. GI disorders/Procedures	☐	☐
k. Heart Disease or Attack/Mitral Valve Prolapse	☐	☐
l. Hepatitis/Liver Disease	☐	☐
m. High Blood Pressure	☐	☐
n. Kidney Disease	☐	☐
o. Pacemaker	☐	☐
p. Prosthetic Hip or Joint	☐	☐
q. Psychiatric Treatment	☐	☐
r. Rheumatic Fever/Heart Murmur	☐	☐
s. Sinus Problems	☐	☐
t. Stomach Ulcers	☐	☐
u. Stroke	☐	☐
v. Thyroid	☐	☐
w. Tuberculosis or other Lung Disease	☐	☐
x. Venereal Disease	☐	☐

	YES	NO
Are you allergic or have you reacted adversely to:		
a. Aspirin	☐	☐
b. Codeine or other Narcotic	☐	☐
c. Erythromycin	☐	☐
d. Latex	☐	☐
e. Local Anesthetics or Novacaine	☐	☐
f. Penicillin or other Antibiotics	☐	☐
g. Tetracycline	☐	☐
WOMEN		
Do you take birth control pills?	☐	☐
Are you pregnant?	☐	☐
If yes, what is your due date? _____		
DENTAL HISTORY		
When did you have your last dental exam? _____		
Dentist name and address _____		
_____		
Have you had problems with your teeth?	☐	☐
If yes, what kind? _____		
Are your teeth sensitive to:		
a. Cold? If yes, where? _____		
b. Hot? If yes, where? _____		
Do your gums bleed easily?	☐	☐
Have you noticed any loose teeth?	☐	☐
Do you brush daily?	☐	☐
Do you floss regularly?	☐	☐
Have you ever had your teeth straightened?	☐	☐
Do you grind or clench your teeth ever?	☐	☐
Do you get oral herpes/fever blisters?	☐	☐
Do you use tobacco products? If yes, what kind?	☐	☐
Chew ___ Cigar ___ Cigarette ___ Pipe ___		
Do you have TMJ/TMD or jaw joint pain?	☐	☐
Do you use nitrous oxide or laughing gas for dental treatment?	☐	☐
Do you have any fillings that feel rough or areas where food collects?	☐	☐
If yes, where? _____		
Have you ever had or been advised to have gum/periodontal therapy?	☐	☐
If yes, when?		
Are you happy with the way your smile looks?	☐	☐
If not, what would you change? _____		
_____		

Patient or Guardian Signature _____ Date _____