

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

Please fill out completely / @AF7, Kag US` fkbVW/dVU`ka` fZ[eXad_ S` Vbq` f[fagffi

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") _____ 7_ VdWUk 5a` fSUF, _____

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: Cigars: Cigarettes: 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 _____