Tillman Family Dental DMD PC

Health Questionnaire

Patient Name: _____

How did you hear about this clinic?

- ❑ Family/Friend
- ❑ Internet Search
- ❑ Insurance Company
- ❑ Website
- ❑ Postcard/Flyer
- ❑ Other

Purpose of Dental Visit:

- Chief complaint _____
- Personal Dental Goals_____

DENTAL HISTORY

- Frequency of visits to the dentist? _____ Types of care received? _____
- Difficulties with past treatment? Y or N
- Date of most recent x-rays? _____
- History of oral-facial injuries (date, type of injury, cause)? _____
- History of TMJ (temporomandibular joint) discomfort/pain/popping/grinding? _____ (date, type of problem, cause)?_____

MEDICAL HISTORY (past and present)

- Are you now or have you been under the care of a physician during the last 12 months? Y or N
  - For what purpose?_____
  - Last time at physician?_____
- Physician's Name? _____ Physician's phone number_____

SURGERY: (date and type of surgery including appendix, tonsils, cosmetic)?

_____

_____

_____

HOSPITALIZATIONS: (for reasons not named above)

_____

_____

ALLERGIES TO MEDICATIONS: (describe reaction, end result)?

_____

_____

MEDICATIONS: (dosage, dosage interval, route, including vitamins)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Females Only: Do you take oral contraceptives? Y or N Are you pregnant (if so, how many months)? _____

FAMILY HISTORY: Do you have or had any biological relatives with any medical condition (diabetes, high blood pressure, seizures, bleeding problems, cancer, other)? _____

_____

SOCIAL HISTORY: Do you use now or have you used any street or recreation drug, tobacco, or consume alcohol (type, amount, frequency)? _____

_____

Do you now have or have you had any of the conditions listed?

Cardiac
- ❑ Shortness of breath
- ❑ Pain, pressure in chest
- ❑ Heart attack
- ❑ Swelling of ankles
- ❑ High, low blood pressure
- ❑ Rheumatic, scarlet fever
- ❑ Heart Murmur
- ❑ Heart valve prolapse
- ❑ Irregular heart beat
- ❑ Prosthetic valves/pacemaker

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Other

Hematopoietic
- ❑ Easy bruising, excessive bleeding
- ❑ HIV infection, AIDS
- ❑ Leukemia, problems with immune system
- ❑ Spleen problems

Extremeties
- ❑ Prosthetic joints

location: _____

Neurological
- ❑ Seizure
- ❑ Paresthesia, numbness
- ❑ Paralysis
- ❑ Stroke

Gastrointestinal
- ❑ Difficulty swallowing, chewing
- ❑ PUD, GERD
- ❑ Jaundice, hepatitis
- ❑ Liver Disease

Endocrine
- ❑ Thyroid trouble
- ❑ Diabetes
- ❑ Excessive thirst

Ear, Nose & Throat
- ❑ Sinusitis
- ❑ Frequent sore throat

Growth or Tumor
- ❑ Radiotherapy
- ❑ Chemotherapy

Respiratory
- ❑ Cough, blood in sputum
- ❑ Bronchitis, emphysema
- ❑ Wheezing, asthma
- ❑ Tuberculosis, exposure to

Eyes
- ❑ Blurring of vision
- ❑ Double vision
- ❑ Drooping of eyelid
- ❑ Glaucoma

Genitourinary
- ❑ Difficulty, pain on urination
- ❑ Blood in urination
- ❑ Excessive urination
- ❑ Kidney Problems
- ❑ Sexually transmitted diseases

Skin
- ❑ Itching
- ❑ Rash
- ❑ Ulcers
- ❑ Pigmentation

Other

_____

_____

I certify that I have answered all of the questions on this two page form and I have answered these questions truthfully and completely. I understand that not answering the questionnaire completely may result in serious complications with my overall health and/or dental treatment. I will not hold the dental clinic, the dentist, or any member of the dental staff responsible for any errors or omissions that I have made. In other words, I assume full responsibility for the accuracy of this questionnaire. I give my permission to discuss any portion of my medical history with my physician and/or pharmacist.

_____ _____

Signature of Patient or Guardian Date

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ _____

Signature of Patient or Guardian Date