Pinckney Family Dentistry

William T Stevenson, DDS
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Health History Questionnaire

Welcome to our Office. Please complete *both* sides of this Dental/Medical history form so that we may provide you with quality dental care.

Patient Name: _____ Date: _____

Please let front desk know if your Dental Insurance has changed.

Address:_____

Telephone _____Your Date of Birth: _____

Has your Dental Insurance changed, if so, please update here: _____

_____

How often do you Brush your teeth? _____How often do you Floss? _____

Please Circle Yes or No if applies to you.

Are any of your teeth sensitive to?

Hot or Cold?	**Yes or No**
Biting or Chewing?	**Yes or No**
Sweets?	**Yes or No**
Do your gums bleed or hurt?	**Yes or No**
Have any mouth odors or bad taste?	**Yes or No**
Have you noticed any loose teeth or change in your bite?	**Yes or No**
Does food get caught in between any of your teeth?	**Yes or No**
If yes, where? _____	

Do you?

Clench or grind your teeth during day or night?	**Yes or No**
Bite your lips or cheeks regularly?	**Yes or No**
Hold foreign objects with your teeth (pencils, pens, chew fingernails)?	**Yes or No**
Mouth breath while awake or asleep?	**Yes or No**
Smoke/chew tobacco or use other tobacco products?	**Yes or No**
Drink Alcohol?	**Yes or No**

Have you ever had:

Orthodontic treatment?	**Yes or No**
Oral Surgery?	**Yes or No**
Periodontal treatment?	**Yes or No**
A bite plate or mouth guard?	**Yes or No**

Have you experienced:

Clicking or popping of the jaw?	**Yes or No**
Pain (joint, ear, side of face)?	**Yes or No**
Difficulty opening or closing?	**Yes or No**
Head, neck or shoulder aches?	**Yes or No**
Are you happy with your teeth's appearance?	**Yes or No**
Do you feel anxious about having dental treatment?	**Yes or No**
If so, what is your biggest concern?	
Have you ever had a negative dental experience?	**Yes or No**
If yes, please describe:	

Have you ever been told to take pre-medication prior to dental treatment? **Yes or No**

If yes, please describe_____Did you take Pre-med today? **Yes or No**

Please complete other side

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Medical History

Primary Medical Physicians Name: _____ Phone: _____
Have you been hospitalized in the last 5 years? _____
Being treated by your Physician for any illness? _____
Women: Are you currently pregnant? **Yes or No** If yes, when is your due date: _____
Do you have any known **Allergies** to (**Latex, Penicillin, Local Anesthetic, Codeine, Food Dye**) any?
Yes or No, if YES please list all Allergies here:_____

Please list current medications in box below:

Please CIRCLE if you have experienced any of the following:

Arthritis	Blood Disease	Glaucoma	Anxiety
Asthma (use inhaler)	Chronic Narcotic Use	High Blood Pressure	Dizziness
ADHD	Cancer	Low Blood Pressure	Migraines
Autistic	Diabetes Type 1	High Cholesterol	Stroke
AIDS/HIV Positive	Diabetes Type 2	Heart Murmur	Heart Attack
Autoimmune Disease	Epilepsy/Seizures	Head Injury	Jaundice
Chest Pain/Angina	Radiation/Chemotherapy	Pacemaker	Hepatitis A, B, C
Sinus Problems	Tuberculosis	Hypoglycemic	Thyroid
Emphysema	Neurological Disorders	Ulcers	Acid Reflux/GERD
Joint Replacement	Sleep Apnea	Heart Surgery	Artificial Heart Valve

Do you have or had any disease, condition, or problem not listed above. Please list below.

Patient/Guardian Signature: _____ Date: _____
Relationship to Patient if Patient is not signing _____