BRUSHDENTAL
DR. CHRISTOPHER G. CARUK

HEALTH QUESTIONNAIRE

To help ensure your well-being while undergoing treatment in our office, please answer the following questions. Information is confidential and for our records only.

Name of Patient ____________________ Medical Alert ____________
In case of emergency, notify ____________________ Phone ____________
Relationship ____________

MEDICAL HISTORY

	YES	NO
1. Do you currently see a physician for a specific or on-going health concern?	☐	☐
2. Have you ever been hospitalized?	☐	☐
3. Have you had any operations or serious illnesses?	☐	☐
4. During the past 12 months have you taken any of the following medication? (Please circle)	☐	☐
Antibiotics or sulpha drugs, Anticoagulants, Medicine for high blood pressure, Tranquilizers, Insulin, Aspirin, Drugs for heart trouble, Nitroglycerin, Cortisone, Steroids, Botox	☐	☐
List other medications here: ____________		
5. Are you presently taking any medication?	☐	☐
6. Do you have allergies or adverse reactions to any of the following? (Please circle) Penicillin or other antibiotics, Sulpha drugs, Local anaesthetics (Freezing), Aspirin, Barbiturates, Sedatives, Codeine.	☐	☐
Do you have any other allergies?	☐	☐
7. (Women only) Are you pregnant? ______ Due Date? ____________	☐	☐
8. Do you smoke?	☐	☐
9. Do you tend to heal slowly?	☐	☐
10. Have you ever had any heart trouble (murmur, heart attack)?	☐	☐

11. Please circle any of the following that you have experienced:

High Blood Pressure	Chest Pain	Jaundice	Radiation Therapy	Cold Sores
Joint Replacement	Stroke	Hepatitis A/B	Ulcers	Sinus Trouble
Rheumatic Fever	Asthma	Thyroid Trouble	Organ Transplant	Venereal Disease
Anemia	Lung Problems	Kidney Problems	Diabetes	HIV/AIDS
Blood Disorder	Tuberculosis	Cancer	Arthritis	Prolonged Bleeding
Blood Transfusion	Liver Disorders	Chemotherapy	Epilepsy	Head or Neck Injury

12. Please note anything else that you think we should know.

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DENTAL HISTORY

1. Reason for today's visit: ☐ Examination ☐ Emergency ☐ Other ____________
2. How frequently do you visit your dentist? ☐ 6 Months ☐ Yearly ☐ Other ____________
3. Last dental visit ________ Last complete examination ________ Last cleaning ________
4. How often do you brush your teeth? ____________
5. How often do you floss your teeth? ____________
6. Do you have a dry mouth? ____________
7. Have you had any serious trouble with past dental treatment? ____________
8. Have you ever been required to take antibiotics prior to dental treatment? ____________
9. Are any of your teeth sensitive to ☐ cold ☐ sweet ☐ heat ☐ biting
10. Do your gums bleed when ☐ brushing ☐ flossing ☐ never
11. Have you ever had difficulty opening your mouth? ____________
12. Please circle any of the following that apply to you:

Loose teeth   Sore gums   Clicking jaw joints   Neck/shoulder pain

Missing teeth   Bad breath/taste   Tooth clenching   Crooked teeth

Full/Partial dentures   Tooth grinding   Headaches   Gagging

Dental anxiety   Orthodontic treatment (braces)

13. Are you concerned about the appearance of your teeth and facial esthetics? If so, what would you like to change?

Color   Straighter   Spaces   Size of teeth   Smile   Gums

Frown Lines   Wrinkles   Crows Feet

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Print Name	**Signature**	**Date**

Medical History Update.... If changes, please inform our staff.

Date	**Same**	**Change**	**Patient/Parent Signature**
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