JOHNSON CREEK DENTAL

Adult Medical History Questionnaire

Name:_____ **Age:** _____**Phone #:**____-____-_____**E-Mail:**_____

Date of Birth:____/____/_____ **Social Security #:**_____/____/_____ **Driver's License:**_____

Address:_____**City:**_____**State:**_____ **Zip:**_____

When were you last seen by your Primary Care Doctor?_____ **What were the results?**_____

Are you being treated for anything at this time? Y / N If yes, for what?_____

Primary Care Doctor's Name:_____ **Clinic Name:**_____

Emergency Contact Name:_____ **Relation to you:**_____ **Contact #:**_____

Please list any medications:

Prescription/ Over the Counter:	Vitamins/Supplements:	Recreational:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List Any Allergies:_____ **(Females) Are you pregnant? Y / N**

Do you know if, or have you ever had any of the following (please circle):

Y / N	Arthritis	**Y / N**	Pacemaker	**Y / N**	Nervous disorders/Psychiatric Care
Y / N	Asthma	**Y / N**	Hepatitis		
Y / N	Abnormal Bleeding	**Y / N**	High Blood Pressure	**Y / N**	Osteoporosis
Y / N	Artificial Joints	**Y / N**	History of Stroke	**Y / N**	Rheumatic Fever
Y / N	Blood Transfusion	**Y / N**	History of Alcohol Abuse	**Y / N**	Thyroid Problems
Y / N	Contact with HIV or AIDS	**Y / N**	History of Drug Abuse	**Y / N**	Tuberculosis
Y / N	Diabetes	**Y / N**	Jaundice	**Y / N**	Venereal Disease
Y / N	Epilepsy	**Y / N**	Liver Disease	**Y / N**	Do you smoke?
Y / N	Fatigue Easily	**Y / N**	Malignancy or Tumor	**Y / N**	Take Medications such as Actonel, Aredia, Fosamax or Zometa
Y / N	Fainting Spells	**Y / N**	Radiation Therapy		
Y / N	Heart Problems	**Y / N**	Heart Valve Problems		
Y / N	Heart Murmur	**Y / N**	Pain in chest upon exertion	**Y / N**	COPD

Please explain any recent hospitalizations or surgeries and dates:

_____

_____

_____

JOHNSON CREEK DENTAL

Adult Dental History

What is your main reason for coming to us?_____

How do you feel about the condition of your teeth? _____

How do you feel about your past dental experiences?_____

Any concerns about your dental treatment?_____**How did you hear about us?**_____

_____

When was your last dental checkup?_____ **Did you have x-rays taken at that visit? Y / N**

Have you been instructed on how to brush or floss? Y / N How often do you floss?_____**-times *per day / week***

How often do you brush?_____**times *per day / week*. What type of toothpaste do you use?**_____

Do you now, or have you ever had any of the following (please circle):

Y / N Clicking or popping in jaw joint
Y / N Clench or grind your teeth at night
Y / N Pain in or near your ear
Y / N "TMJ" Splint or other type of treatment
Y / N Painful or sore areas in mouth
Y / N Any missing Teeth
Y / N Bleeding Gums
Y / N Offensive or bad breath
Y / N Pain when chewing
Y / N Canker Sores
Y / N Sensitivity to cold or hot
Y / N Root canal treatment
Y / N Bridgework or partial denture
Y / N Periodontal treatment
Y / N Orthodontic treatment
Y / N Regular dental check-ups

Does your diet include any of the following? (please circle):

Y / N Chewing Gum
Y / N Cookies/ Pastries
Y / N Candy Bars
Y / N Sugar in coffee or tea
Y / N Hard candy
Y / N Soft Drinks
Y / N Fruit Juice
Y / N Sports drinks
Y / N Breath Mints

I HAVE READ THE JOHNSON CREEK DENTAL HIPAA PRIVACY RULE ACT (located by front desk)

Signature:_____**Date:**_____

Signature of treating Dentist_____**Date:**_____