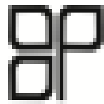

BERKS PROSTHODONTICS
ADVANCED IMPLANT AND RESTORATIVE DENTISTRY

MEDICAL QUESTIONNAIRE

All information is completely confidential.

Doctor/Physician Name ____ Phone _________________________

Date of last physical exam _________________________ Height _________________ Weight __________________

Check any of the following that you HAVE HAD or HAVE at present

O Heart Attack	O Stroke	O Diabetes: Type_____	O Artificial Joints
O Heart Disease/Stents	O Seizures	O Hepatitis/Liver Disease	O Endocarditis
O High Blood Pressure	O Fainting	O Kidney problems	O Depression/Anxiety
O Chest Pain	O Asthma	O Thyroid problems	O Psychiatric Treatment
O Congestive Heart Failure	O Bleeding	O GERD/Reflux	O Drug/Alcohol Addiction
O Pacemaker	O Blood Clots	O HIV/AIDS	O Currently Pregnant/Nursing

O Other ____

	YES	NO
Has your health changed in the past year? If yes, what condition has changed?_______________________	O	O
Have you been hospitalized during the past 5 years? If yes, why?___________________________________	O	O
Have you ever had a major operation, including joint replacement? Please list________________________ ____	O	O
Have you been told by your medical doctor to take antibiotics before any dental treatment? _____________	O	O
Have you had radiation treatment of the head and/or neck area to treat cancer? ______________________	O	O
Have you ever taken bisphosphonate drugs, such as Fosamax, Actonel, Boniva, Reclast, or Zometa?_____	O	O
Do you take erectile dysfunction medications for any reason, such as Viagra, Cialis, Levitra, Avanafil? __	O	O
Do you smoke or use tobacco products? If yes, how much and how frequently?______________________	O	O
Are you comfortable lying flat to sleep? ____	O	O
Do you snore or have sleep apnea? ____	O	O

Are you allergic to or have you reacted adversely to any of the following

O Penicillin O Sulfa Drugs O Novocaine O Codeine O Latex O Acrylic O Metals

Other Allergies ____

Please list all medications and supplements you are currently taking

Medicine ____Condition _______________________________

Medicine ____Condition _______________________________

Medicine ____Condition _______________________________

Medicine ____Condition _______________________________

Medicine ____Condition _______________________________

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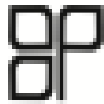

BERKS PROSTHODONTICS

ADVANCED IMPLANT AND RESTORATIVE DENTISTRY

DENTAL QUESTIONNAIRE

Who is your most recent dentist? ______________________________ When were your last dental x-rays? ___________

When was your last dental visit? ____________ What was done at that visit? ___________________________________

	YES	NO
Are you having dental pain or discomfort? Please explain____	O	O
Are your teeth sensitive to heat, cold, or pressure? ____	O	O
Do your gums bleed while brushing or flossing?____	O	O
How often do you brush? ___________ Floss? ___________ Do you use an electric toothbrush? _______	O	O
Have you ever experienced any of the following problems with your jaw? __________________________	O	O
Circle: Noise/Popping Pain Locking Difficulty chewing Headaches		
Do you clench or grind your teeth? ____	O	O
Have you ever had orthodontic treatment/braces? ____	O	O
Do you wear removable dentures or partials? If so, how old are they? ______________________________	O	O
Do you wish your teeth looked better? ____	O	O
Do you use anti-anxiety medications or nitrous oxide (laughing gas) for dental visits? ________________	O	O
Have you ever had any serious problems with dental treatment?___________________________________	O	O

Have you seen other dental specialists (prosthodontist, oral surgeon, periodontist, orthodontist, endodontist)? Please list.

____

The information that I have given today is correct to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes. I do not hold my dentist or any staff member responsible for any action they take or do not take as a result of errors or omissions in my completion of this form.

____

Patient Signature Date

In the event of an emergency please contact:

Name _____________________________________ Relationship_____________ Phone ________________________

Medical/dental health reviewed by

____

Doctor's Signature Date

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