Paul A. Fugazzotto, D.D.S **Anya Rost, D.D.S.**

Health Questionnaire

Dr./Mr./Mrs./Ms. Date _____

Name_____

Address_____

Phone (home) _____ (work) _____ (cell) _____

contact preference: ☐ work ☐ home ☐ cell

email: _____

Referred by: _____

Email:_____

S.S.#: _____/_____/_____ Birth date: _____

Family Dentist: _____ Address: _____

Family Physician: _____Date of last physical:_____

****Please bring your dental insurance card(s) with you to your appointment****

Dental Benefit Provider:

Employer of Insured: _____

Ins. Company Name: _____

Subscriber ID#: _____ Group # _____

Subscriber Name:_____ DOB _____/_____/_____

Secondary Dental Benefit Provider:

Employer of Insured: _____

Ins. Company Name: _____

Subscriber ID#: _____ Group # _____

Subscriber Name:_____ DOB _____/_____/_____

Medical History

Have you been under the care of a physician in the last 5 years? ☐ yes ☐ no

If so, please explain:_____

Have you ever had a serious illness? _____ Please explain:_____

Have you ever had an artificial prosthesis surgically placed?_____

Have you ever been tested for HIV? ☐ yes ☐ no If yes, result: ☐ Positive ☐ Negative

Please list all medications you are taking:_____

_____ For what purpose?_____

Do you take medications for osteoporosis? ☐ yes ☐ no Please List:_____

Do you take any blood thinners: ☐ Yes ☐ No

Please list_____

Please list any medications you are allergic to, if any: _____

Have you ever been treated for any of the following:

	YES	NO		YES	NO
Heart Disease	☐	☐	Ulcers	☐	☐
Heart Murmur	☐	☐	Glaucoma	☐	☐
High Blood Pressure	☐	☐	Stroke	☐	☐
Blood Disorders	☐	☐	Arthritis	☐	☐
Liver Problems	☐	☐	Nervous Disorder	☐	☐
Hepatitis	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Sinus Trouble	☐	☐
Epilepsy	☐	☐	Lung Disorder	☐	☐

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Have you ever had abnormal bleeding following a cut or dental extraction: ☐ Yes ☐ No
Do you suffer from frequent or severe headaches? ☐ Yes ☐ No
Have you ever had radiation and/or chemo therapy? ☐ Yes ☐ No
Do any of your blood relatives have diabetes? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No How much?_____
So you get shortness of breath after climbing one flight of stairs? ☐ Yes ☐ No
Do you get pain in your chest or over your heart? ☐ Yes ☐ No

Dental History

Please describe your present dental problem:_____
_____

Are you having any discomfort or pain? ☐ Yes ☐ No
If yes, where?_____
Do you feel you have enough teeth to chew with? ☐ Yes ☐ No
Do your gums bleed when you brush or floss? ☐ Yes ☐ No
Do you frequent a "bad taste" in your mouth? ☐ Yes ☐ No
Are your teeth sensitive to hot, cold or sweets? ☐ Yes ☐ No
Does your jaw ache when you awake in the morning? ☐ Yes ☐ No
Are you aware of any loose teeth? ☐ Yes ☐ No
Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
If no, why?_____
If you have a removable partial plate, or a denture, is it comfortable for chewing and speaking? ☐ Yes ☐ No
If not, would you be interested in more "permanent" teeth? ☐ Yes ☐ No
Has anyone ever spoken to you about the advantages of dental implants? ☐ Yes ☐ No
Have you ever had orthodontic therapy (braces)? ☐ Yes ☐ No
Have you ever had prior periodontal therapy? ☐ Yes ☐ No
When?_____

Signature_____ Date: _____/_____/_____

Are you pregnant: ☐ Yes ☐ No
If so, how many months?_____
Are you taking birth control pills? ☐ Yes ☐ No
Are you taking hormones? ☐ Yes ☐ No

If you have a prosthesis, please call **before** your appointment, as you need antibiotic premedication.

Thank you!