Kirt Kirchmeier, DMD

Review Completed

_____ _____
Dr. or Hygienist signature date

Notes:_____
_____
_____
_____

HEALTH QUESTIONNAIRE FORM

Name:_____ Date of Birth _____

Address:_____

Phone: _____ Cell: _____ Work:_____

Medical Doctor's Name:_____Phone:_____

Are you currently taking any medications: ☐ NO ☐ YES If yes, list medication and dose below:

Medication	**Dose**	**Medication**	**Dose**
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Have You Ever Been Treated For:

	YES	NO
Kidney Problems……	☐	☐
Cancer……	☐	☐
High / Low (circle) Blood Pressure...	☐	☐
Diabetes……..……	☐	☐
Epilepsy/Seizures…...……	☐	☐
Sinus trouble……..……	☐	☐
Stroke……...……..	☐	☐
Thyroid Disorder……	☐	☐
Osteoporosis ……..….	☐	☐
Heart Disease…….....	☐	☐
Asthma…..……..…….	☐	☐
Tuberculosis or lung disease……...	☐	☐
Hepatitis B or C/ Liver trouble….....	☐	☐
Arthritis……...	☐	☐
Women: Are you pregnant:……	☐	☐
Trimester?_____		
Are you taking birth control?……..	☐	☐

	YES	NO
Are you H.I.V. positive?……..…	☐	☐
Are you subject to prolonged bleeding?.....	☐	☐
Have you ever had surgery?…….....…..	☐	☐
Do you use tobacco products? …….……....	☐	☐
Do you require antibiotics prior to dental work? (heart valve replaced or artificial joint)..	☐	☐
Date of joint/valve replacement:_____		
Do you wear a pacemaker?… ……..……....	☐	☐
History of alcohol or drug abuse……..…..	☐	☐
Are You Allergic to:		
Penicillin/Antibiotics……..……...	☐	☐
Dental anesthetic……..……..	☐	☐
Latex ……...…..	☐	☐
Codeine ……..	☐	☐
Other medications……..…….	☐	☐
List:_____		

Have you been hospitalized in the past two years or under the care of a physician? Yes or No
Reason for hospitalization: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Kirt Kirchmeier and his staff to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform Dr. Kirchmeier prior to dental treatment being performed.

Date:_____

Patient or Parent signature:_____Print Name:_____

Guardian/Legal rep signature: _____Print Name:_____

~ Turn Over ~

Dental Health

When was your last dental treatment? _____
How would you rate your overall dental health? Excellent □ Good □ Poor □
How would you rate the appearance of your teeth? Excellent □ Good □ Poor □

	Yes	No
Are you apprehensive about dental treatment?	□	□
Have you had problems with previous dental treatment?	□	□
Do you gag easily?	□	□
Do you wear dentures?	□	□
Does food catch between your teeth?	□	□
Do you have difficulty chewing your food?	□	□
Do you chew on only one side of your mouth?	□	□
Do you avoid brushing any part of your mouth because of pain?	□	□
Do your gums bleed easily?	□	□
Do your gums bleed when you floss?	□	□
Do your gums feel swollen or tender?	□	□
Have you ever been treated for periodontal disease?	□	□
Are your teeth sensitive?	□	□

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids……□ Yes □ No
Sour foods……□ Yes □ No
Sweets ……□ Yes □ No

	Yes	No
Are you dissatisfied with the appearance of your teeth?	□	□
Have you ever or would you like to bleach your teeth?	□	□
Is there anything about your teeth that you would like to change?	□	□
Do you prefer to save your teeth?	□	□

How often do you brush?_____ How often do you floss?_____

	Yes	No
Do you clench or grind your jaws frequently?	□	□
Do your jaws ever feel tired?	□	□
Does your jaw get stuck so that you can't open freely?	□	□
Does it hurt when you chew or open wide to take a bite?	□	□
Do you have jaw symptoms or headaches upon awaking in the morning?	□	□
Do you have temporomandibular (jaw) disorder (TMD)?	□	□
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	□	□
Have you ever had orthodontic treatment (braces)?	□	□